3928

PROMOTING MENTAL HEALTH SERVICES FOR REFUGEES

A Handbook on Model Practices

April 1991

U. S. department of Health and Human Services
Family Support Administration
Office of Refugee Resettlement

Produced under contract with:
Lewin/ICF
a division of
Health & Science International
and
Refugee Policy Group

Prepared for the U.S. Department of Health and Human Services, Family Support Administration, Office of Refugee Resettlement, 370 L'Enfant Promenade, S.W., Washington, D.C. 20447, under contract # DHHS 282-87-1001. For additional information, please call (202) 401-9250

PROMOTING MENTAL HEALTH SERVICES FOR REFUGEES

A Handbook on Model Practices

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Family Support Administration
Office of Refugee Resettlement

April 1991

PROMOTING MENTAL HEALTH SERVICES FOR REFUGEES:

A HANDBOOK ON MODEL PRACTICES

Table of Contents

PROMOTING MENTAL HEALTH SERVICES FOR REFUGEES:

A HANDBOOK ON MODEL PRACTICES
(continued)

Table of Contents

PROMOTING MENTAL HEALTH SERVICES FOR REFUGEES:

A HANDBOOK ON MODEL PRACTICES
(continued)

Table of Contents

PROMOTING MENTAL HEALTH SERVICES FOR REFUGEES:

A HANDBOOK ON MODEL PRACTICES
(continued)

Table of Contents

PROMOTING MENTAL HEALTH SERVICES FOR REFUGEES:

A HANDBOOK ON MODEL PRACTICES
(continued)

Table of Contents

INTRODUCTION

This handbook is designed to help refugee advocates and service providers increase the availability of culturally sensitive and linguistically appropriate mental health services for refugees. It is part of an ongoing series of efforts undertaken by the Federal Office of Refugee Resettlement (ORR) to enhance accessibility of refugee mental health services. The handbook grew out of the evaluation of the ORR-funded Refugee Assistance Project -- Mental Health (RAP-MH) which was administered by the National Institute of Mental Health. The RAP-MH initiative funded states to establish a focal point within their mental health systems and engage in efforts to make appropriate mental health services more available to refugees.

The handbook presents case studies of refugee mental health programs that have been implemented in different localities around the country. Some of the programs resulted from the RAP-MH initiative, but many did not. All of the projects described in the handbook have been able to sustain their operations over a period of time. They are located within various institutions including mainstream mental health agencies, hospitals, and community health centers. Since the thrust of the handbook is to discuss efforts that have improved the capacity of mainstream U.S. providers to respond to the needs of refugees, it does not include information on traditional healers. Users of the handbook may want to explore ethnic-based services available in their own communities.

Each case study provides information about how the program was established, the range of services that are offered, the target populations, fundraising strategies, the design of the service systems, and staffing. Each case study also offers a summary of "key elements" or factors that enabled the program to become established and respond effectively to the needs of refugees. The handbook concludes with a summary of lessons learned from the case studies, and guidelines for developing local service capacity. The handbook does not address clinical or therapeutic approaches for refugees since sources on this topic are readily available elsewhere, such as the University of Minnesota Technical Assistance Center (TAC).

The handbook was prepared for a wide range of persons and organizations seeking to make effective mental health services more available to refugees, including:

- Refugee state coordinators;
- Voluntary resettlement agencies;
- Refugee employment and social service providers;
- Ethnic leaders and Mutual Assistance Associations;
- Mental health advocacy organizations;
- Health care providers serving refugees; and
- Other refugee advocates.

Mental health professionals who work with refugees or who are interested in developing and/or expanding services for refugees may also find practical suggestions here for design and implementation of programs.

The handbook is organized as follows:

- **PART I:** Mental Health Needs of Refugees reviews the mental health problems of refugees, barriers they face in obtaining care, and Federal efforts to make appropriate mental health services more available.
- PART II: Case Studies presents a series of case studies documenting efforts to enhance services for refugees at the local level.' These case studies focus on five different strategies applied in various localities around the country:
  - -- Refugee Capacity in a Mainstream Mental Health Agency;
  - -- Mental Health Services in a Primary Health Care Setting;
  - -- Refugee Services in an Ethnic Agency;
  - -- Specialized Refugee Mental Health Clinics; and
  - -- Mobile Team Approach.

[1] The case study projects presented in this handbook were selected to illustrate a range of possible approaches on behalf of refugees. They are not an exhaustive set of "model practices," however. Other promising mental health programs for refugees may be available in various communities,

- **PART III:** Lessons Learned provides guidelines for the local advocate or program administrator who is seeking to establish culturally sensitive mental health services for refugees. These guidelines fall within four categories:

  -- Building Support for Refugee-Specific Services;

  -- Designing the Program;

  -- Financing the Program; and

  -- Staff Recruitment and Development.

Appendix A is an index to the "lessons learned" and examples from the case studies. The index can be used to locate relevant pages from the case studies that may serve as useful models for particular issues or efforts. **Appendix B** lists the addresses and phone numbers for each of the case study projects.

PART I:
MENTAL HEALTH NEEDS OF REFUGEES

The status of refugees' physical and mental health is one of the major factors affecting their social adjustment and integration. Refugees are doubly disadvantaged regarding their mental health status. First, many refugees suffer the effects of the very situations that made them refugees. The literature on refugee mental health, including needs assessments conducted by the state mental health departments that received NIMH grants to establish refugee offices, shows a consistent pattern of problems related to the past experiences of refugees.' Second, refugees find it difficult to gain access to mental health services, This chapter describes the mental health problems faced by refugees, barriers to access, and efforts by the Federal government to overcome these barriers.

A. MENTAL HEALTH PROBLEMS

For many refugees, the experiences that generate mental health problems include months, if not years, of war and/or repression, the uncertainties and dangers of flight, and prolonged stays in refugee camps. The following traumatic experiences are not uncommon: loss of family members in an unnatural manner; lack of food and water during escape; robbery, rape, or torture; and witness to the killing of relatives and friends. Common symptoms experienced by survivors of traumatic events include depression, anxiety, intrusive thoughts, disassociation or psychic numbing, hyperalertness, and sleeping and eating disorders. The most serious mental health problems of refugees may manifest themselves in severe depressive behavior, self-destructive behavior, violent or disruptive behavior, alcohol or drug abuse, and a high degree of psychosomatic illness.

---

[1] As described in the preface, the Office of Refugee Resettlement (ORR) sponsored a three-year initiative designed to make appropriate mental health services more available to refugees. Administered by NIMH, the initiative provided funding to states to establish a focal point within the state mental health system, and to engage in efforts aimed at changing mental health systems. One such effort was to conduct needs assessments, several of which resulted in some of the information presented in this chapter.

Arrival in a new country does not necessarily mean an end to the problems experienced by refugees. Research indicates that Post-Traumatic symptoms may persist as long as twenty years after the refugee experience. In fact, resettlement may itself be a stressful enough process that new problems emerge. Studies on refugees, as with other immigrants, have indicated that difficulties associated with adaptation to a new socio-cultural environment and the dramatic life changes that newcomers are forced to make increase the potential for the development of mental and physical disorders.

The needs assessments sponsored by NIMH as part of the Refugee Assistance Program (RAP-MH) reference several specific adjustment problems that can exacerbate the mental health problems of refugees. Foremost among them are language difficulties, housing problems, and employment. Family problems also emerge, particularly when younger members adapt more quickly to the new culture.

Actual or even estimated numbers of refugees with mental health problems cannot be determined. A cultural reluctance among refugees to seek help results in recurrent underestimates of the problem. In addition, some problems do not surface immediately; a delayed reaction to an earlier trauma is a well-known phenomenon. By the time the problems become apparent, the individuals may no longer be seen and treated as refugees.

The difficulty in estimating the scope of mental health problems among refugees stems also from the fact that for a large number of refugees, the experience of mental distress -- anxiety, grief, depression -- is expressed under the guise of physical symptoms: headaches, fatigue, nervousness, insomnia. This tendency to somatize emotional problems is particularly common among refugees who come from societies that do not have a Western psychiatric tradition. In some of these societies, disease is explained by the actions of deities, ancestors, or demons who infiltrate their victims, causing confusion, fever, and distress.

Reliable statistics on specific disorders are also lacking. Many mental health providers encounter difficulty in conducting an accurate diagnosis, For example, a study of public mental health centers in one state revealed that 209 out of 355 refugee patients had

had no diagnosis made. The researchers concluded that the high number with no diagnosis resulted from communication difficulties (such as language barriers) faced by the mental health professional as well as the fact that problems presented by the refugees did not always fall into traditional mental health diagnostic categories. An examination of state hospital admissions in a second state showed that almost 60 percent of the refugee patients were diagnosed as schizophrenic, but the study raised questions about the diagnosis. Only 11 percent of the cases had an interpreter although almost 30 percent of the patients had no knowledge of English and another 50 percent had limited knowledge. Moreover, information on issues needed for a more accurate diagnosis, such as the past traumatic experiences of the patients, was not found in their records.

The NIMH-sponsored needs assessment performed by the state of Massachusetts tried to gauge which subgroups are most at risk through a key informant survey. These subgroups differed in their needs by nationality. Among Vietnamese, the five subgroups most at risk of mental illness, in rank order, were: minors with parents living in Vietnam; adolescents, ages 13-19; single adults; single heads of households; and the elderly. In addition, Vietnamese veterans and Amerasians were considered to be particularly at risk. Among Cambodians, those most at risk were: single heads of households; adolescents, age 13-l 9; widows/widowers; unaccompanied minors; and persons from a low socioeconomic background. For Haitians, those most at risk were: persons from a low socioeconomic background: elderly; adolescents, age 13-19; single heads of households; and women.

A study of socioeconomic adjustment of Afghan, Ethiopian, Polish and Rumanian refugees reported incidents of depression, suicide, violence, and homelessness among Ethiopians; a tendency toward heavy alcohol consumption among Poles; persistent mental health problems among Afghan refugees who had been jailed in Afghanistan; and incidents of domestic violence among all studied groups.

B. ACCESS TO AND UTILIZATION OF MENTAL HEALTH SERVICES

Despite the existence of mental health problems among refugees, there are formidable barriers to their access to appropriate services. Some of these barriers come from

within the refugee community itself, but others are more symptomatic of systemic problems within the mental health system.

1. Cultural Barriers

In a number of the cultures from which refugees come, great stigma is attached to acknowledging mental health problems. Despite mental distress, it is not easy for many Indochinese refugees, for example, to accept psychiatric referral because of traditional negative attitudes towards the mentally ill. These attitudes include fear, rejection, and ridicule.

The NIMH-sponsored needs assessment in Massachusetts provides illustrative examples, Key informants ranked the following reasons as the major barriers for Vietnamese, Cambodians, and Haitians in accessing mental health services: "being uncomfortable sharing problems with a stranger"; "lack of understanding of mental health concepts"; "afraid of stigma" (more commonly cited among the Vietnamese than among Cambodians or Haitians); and "feels ashamed going to a mental health center."

The feelings of shame are accentuated by a general reluctance within the refugee community to highlight the mental health problems of refugees. The refugee leadership indicated, through the needs assessments, their concern that refugees as a group will be labeled as mentally impaired by the broader American community if too much attention is placed on mental health issues. Such labeling, they fear, would raise questions about the advisability of admitting more refugees into the U.S. and could contribute to discrimination and intolerance by U.S. communities.

Referral of family and friends to mainstream mental health services generally occurs only as a last and desperate resort. As the NIMH-sponsored needs assessment in Washington indicated:

> Treatment is considered appropriate only for those individuals who are "crazy." This means that there is no system of early detection of mental illness. The refugee community does not see a need for the early referral of mental illness. Part of the reason for this, of course, is the

social stigma attached to being labelled crazy, but the other part is the refugee community's lack of knowledge regarding availability of treatment during early stages of mental illness. In Southeast Asia, the only form of treatment is institutionalization. Once an individual is placed in an institution, he is there for life without any expectations of recovery or returning to the community.

2. Systemic Barriers

Even where the cultural barriers within the refugee community are overcome, access to appropriate mental health services is impeded by barriers within the mental health system:

- Language barriers -- Most mainstream mental health facilities do not have bilingual personnel who can provide treatment in the client's language or interpret for other professionals.

- Lack of cultural knowledge and sensitivity -- Mental health professionals often do not have adequate understanding of the cultural biases and experiences of their refugee patients, thereby making it difficult for them to diagnose and develop appropriate treatment plans.

- Emphasis on chronic, severely mentally ill patients -- Most state and local mental health systems are moving toward concentrating their attention on the chronically mentally ill. In many places, this focus translates into funding priority for those persons who have been released from a state mental health hospital. Few refugees have entered these facilities. The emphasis on the chronically mentally ill also means fewer counseling and adjustment services, preventive programs, or outreach and education programs.

These barriers are of particular concern because of the profile of service system needs developed by the states that received NIMH grants. A review of their needs assessments reveal a consistent set of characteristics that should define refugee mental health services:

- Use of trained bicultural staff;

- Cross-cultural teams and interpreter services, particularly where there is an inadequate number of bilingual mental health professionals;

- Training for Western mental health providers regarding cultural beliefs and traditions of refugee patients;
- Community outreach and education regarding the availability and utilization of mental health services; and
- Improved models for combining Western and traditional treatment modes, particularly for refugees who have undergone traumatic experiences,

C. EFFORTS TO OVERCOME THE BARRIERS

The Federal refugee program has promoted several efforts to improve the availability of mental health services for refugees. Between 1976 and 1979, the Office of Refugee Affairs (the predecessor to ORR) directly funded a number of mental health projects in communities with large numbers of refugees. These grants were one of several major social service initiatives, the others focusing on language training, employment, orientation and health services. The funds available for mental health services totaled $5 million.

In 1980, with passage of the Refugee Act, the Federal government stopped its funding of social services at the local level. Instead, ORR provided social service grants to state refugee offices that then contracted with local service providers. The continued funding of mental health services varied considerably. A number of organizations that received funding during the earlier period received funds from the state refugee offices; others found alternative funding sources; still others ceased services after their special Federal refugee funding ended. In later years, however, as states began concentrating more of their attention on employment services, in response to Federal directives, much of the funding for mental health services through the regular refugee social service grants stopped.

Recognizing that refugee mental health problems continued to be of concern, ORR initiated two programs using discretionary grants aimed at increasing the availability and improving the delivery of services. One program provided funds for the retraining of refugee health and mental health professionals and paraprofessionals. The other supported demonstration projects that fell into three categories:

- Training in the detection of mental health problems, methods of referral and crisis intervention, and crisis management techniques for nonprofessionals, including service providers and community leaders.

- Development of one or more service delivery models for integrating refugee mental health professionals and paraprofessionals into mainstream service systems.

- Development of mental health service models using indigenous healing practices.

Of the eight demonstrations funded in the FY 1983, several have become well established and highly regarded programs. Two are used as case studies in this handbook: The Metropolitan Indochinese Children and Adolescent Services (MICAS) in Boston and services at the Community University Health Care Center (CUHCC) in Minneapolis. Other programs featured in this handbook also benefitted from direct ORR support, including mental health services at the Asian/Pacific Center for Human Development in Denver and the Southeast Asian Women's Alliance in Seattle.

In 1984, ORR established a Workgroup to make recommendations about new strategies for addressing refugee mental health problems, particularly through efforts to make mainstream services more responsive. Out of that process came a decision for a cooperative initiative funded by ORR and administered by the National Institutes of Mental Health. Twelve states received funding to establish a Refugee Assistance Program (RAP-MH). In addition, a technical assistance center (TAC) was established at the University of Minnesota to provide expert advice to the RAP-MH offices. Total funding for this initiative exceeded $6 million over a three year period, with individual grants to states ranging from $75,000 to $200,000 per year.

The RAP-MH offices met with both successes and failures in achieving their ultimate objective: to increase the capacity of the state mental health systems to provide linguistically and culturally appropriate services to refugees. The programs were generally successful in bringing the needs of refugees to the attention of the state mental health departments, and, to a lesser degree, other institutions involved in the delivery of mental health services within the state. In general, however, the increased attention did not translate

into improvements in the capacity of the state mental health systems to respond to the special needs of refugees.

To some extent, the failures were due to problems the RAP-MH offices had in implementing the activities required by the strategy. More importantly, the problems that the. RAP-MH programs faced reflected serious constraints within the state mental health systems: decentralized decision-making which gives any state office limited ability to influence decisions at the local level; and financial constraints that would require funds for refugees to be taken away from other programs or groups.

Activities aimed at the state mental health departments, while useful in laying the groundwork for change, were not sufficient in themselves in stimulating service delivery at the local level. Most localities control decisions over funding for the types of services that are most appropriate to refugee needs -- outpatient counseling and treatment. In fact, where RAP-MH programs met with the most success their accomplishments resulted from concentrated efforts to convince local decision-makers to establish specific services or agency capabilities at the local level. This research finding has led to the latest in ORR's efforts to improve refugee mental health services -- this handbook of model programs in localities throughout the United States.

D. CONCLUSION

The vast majority of refugees never come to the attention of the mainstream mental health system. For many refugees, this is not a problem. They have adjusted to their new lives in the United States and resolved satisfactorily the emotional legacy of their refugee experiences. Or, they have found help and counsel within their own communities from religious institutions, social service agencies, or their own families.

For another segment of the refugee population, however, lack of access to mental health services may be more problematic. They are suffering from or are acutely susceptible to severe depression, Post Traumatic Stress Disorder, and other mental illnesses, but they are

not receiving assistance in dealing with their problems. When they enter services, what they find is often characterized as too little and too late.

Changing this situation requires education within the refugee community as well as adaptations in the mental health system to overcome the barriers to access for appropriate services. Advocates on behalf of refugees can do much to help improve the availability of needed services, particularly if the focus is on local initiatives.

The next part of this handbook provides a series of case studies of model program efforts that have been implemented in localities throughout the United States. While differing in clinical approaches, target client populations, and institutional settings, these model programs echo a common theme: they have succeeded in establishing ongoing capacity to respond to the mental health needs of refugees within their communities, The case studies describe how these model programs have achieved this capacity.

PART II:

CASE STUDIES

CHAPTER ONE:
REFUGEE CAPACITY IN A MAINSTREAM MENTAL HEALTH AGENCY

Several of the more promising efforts to address refugee mental health needs in the US. have developed within community mental health centers or other mainstream mental health agencies, This approach entails the use of paraprofessional bicultural staff to support or supplement the traditional, professional model of mental health therapy. In some cases, the bicultural staff comprise a separate unit within the agency that provides direct support and counseling to refugees, supplemented by professional therapy as needed. In others, the bicultural staff provide support to professional therapists but conducted little in the way of independent counseling for refugee clients.

A prominent advantage of a mainstream approach is the ability to merge traditional American mental health therapies with the cultural and language needs of refugees. This is not an easy process, however. Refugees are often ambivalent about American mental health approaches, and American-born professionals can be slow to recognize and incorporate the cultural needs of their clientele into therapeutic protocols.

This chapter presents three programs entailing the use of bicultural staff in mainstream agencies:

- Zumbro Valley Community Mental Health Center and "New Hope" (Rochester, MN).
- The Southeast Asian Mental Health Unit in Fresno (Fresno, CA).
- Bilingual refugee services in the Solomon Community Mental Health Center (Lowell, MA).

A. ZUMBRO VALLEY COMMUNITY MENTAL HEALTH CENTER AND "NEW HOPE" (Rochester, Minnesota)

The New Hope program offers social adjustment services and mental health therapy for the largely Southeast Asian refugee population of Rochester, Minnesota. Comprised of a director and four bicultural workers, the program is situated within the Zumbro Valley Community Mental Health Center, a full-service community mental health center (CMHC). Assistance to refugees is offered directly by the bicultural counselors and through team arrangements with American-born professionals, depending on the severity of the condition. Over 100 refugees, mostly Cambodian and Vietnamese, were served by the program last year.

The New Hope program illustrates the promise of having a bicultural team of paraprofessional counselors in a mainstream mental health agency. The program has enabled the Center to reach a needy population by bridging the cultural and language gap that so often deters access to mainstream services by refugees,

1. Mental Health Services in Minnesota and Rochester

Mental health services in Minnesota are largely decentralized. The state mental health agency makes general funding and programmatic decisions, but the counties provide a substantial share of the funding and are responsible for designing service approaches for their communities, The Zumbro Valley Community Mental Health Center serves the communities of Olmsted County (Rochester), Minnesota, an area with approximately **100,000** inhabitants. It is a full-service community mental health center, rendering care for both the chronically mentally ill and those afflicted with less serious emotional disorders. Funding comes from both the state and the county. Zumbro Valley also offers various programs for targeted subpopulations in the Rochester area.

2. The "New Hope" Program

The "New Hope" program is offered to the 3,300 mostly Southeast Asian refugees living in Olmsted County. The aim of New Hope is to provide assistance in social adjustment for these refugees, including help with depression, anxiety, employment adjustment, school issues, substance abuse, and family and intergenerational conflicts, To this end, counseling, support groups (e.g., for the chemically dependent), and referrals are offered to the majority groups of Cambodians and Vietnamese, as well as to the Lao and Hmong.

New Hope also provides mental health services to more severely, mentally ill refugees, These services are provided by licensed therapists for various disorders, including multiple personality disorders, paranoia, Post-Traumatic Stress Disorder, somatization, and follow-up for those who have been institutionalized. The bicultural workers often assist with the therapy sessions.

Recipients of New Hope's services were as follows in 1988:

	Social Adiustment	Mental Health Counseling and Therapy	Chemical Dependency	Total
Refugee Group				
Cambodian	42	12	6	60
Vietnamese	22	7	2	31
Lao	7	2	2	11
Afgani	2	2		4
Hmong	1			1
Total	74	23	10	107

Four bicultural workers and a program director are the core of the New Hope program. Two of the workers are Cambodian, one is Vietnamese, and one Lao, reflecting the caseload composition of the program.

Because the bilingual workers have achieved a high degree of familiarity and comfort with the issues of refugee social adjustment, they have some autonomy in treating

refugees who seek mental health assistance. For example, a Cambodian woman co-leads the support group for older women and a Vietnamese man co-leads the support group for chemically dependent men. Furthermore, the bilingual workers constitute the first contact with the formal mental health system for many referrals. As such, the workers do an initial assessment of needs and consult with a Zumbro Valley professional therapist, Depending upon the nature of the difficulties, the bilingual worker may continue to be the primary provider for the refugee with assistance and close supervision by a licensed therapist. In general, a licensed therapist and a bicultural worker will work together to provide each individual with the help he/she needs.

Occasionally, the team of health care providers operates as one of professional therapist and interpreter. In situations where treatment rather than steps toward social adjustment are required, the bicultural worker serves primarily as the translating conduit for therapy directed by the licensed professional. In these instances, the bicultural worker may play no more active role than translating the professional's words into a cultural context a refugee can understand.

3. Origin and Development of the Service

Since the latter part of the 1970s, Southeast Asians have been coming to the small communities south of Minneapolis-St. Paul. Home to an International Business Machines manufacturing plant and the Mayo clinic, the city of Rochester has helped refugees find and establish homes there and in surrounding areas. The most involved and knowledgeable organization assisting in this effort has been the Olmsted County Intercultural Mutual Assistance Association (IMAA). A United Way member agency for a time, the IMAA received substantial Federal funding to provide a variety of services to refugees. For example, it received funding from the state refugee office (known as RIAD -- the Refugee Immigration and Assistance Division) for employment and related services, bilingual services, and case management. Shortly after the IMAA hired its first bilingual workers (Cambodian and Vietnamese), the IMAA recognized that a great need for mental health services, particularly those for social adjustment, existed among the Southeast Asian refugees. After an initial refusal by the state to finance a program for social adjustment services with a Federal mental

health block grant (due to the IMAA's lack of mental health expertise), the IMAA contracted with the director of adult services at the Zumbro Valley Mental Health Center (who is currently the executive director of the Zumbro Valley Community Mental Health Center) to assist in writing a proposal and providing social adjustment services to refugees in Olmsted County.

As a result of this joint effort, Federal block grant funds from the Mental Health Division of Minnesota's Department of Human Services were provided to the IMAA in 1986. The funds covered the services of a part-time director and 1.5 bilingual full-time equivalents (FTEs) to provide social adjustment counseling to Southeast Asian refugees. The Zumbro Valley Mental Health Center provided a mental health consultant as the director to assist the IMAA.

During this first year of the grant, the therapists became familiar with the unique difficulties refugees face in starting a new life. The bilingual workers, already identified as "natural helpers" and leaders within their communities, studied the language of mental health, began to discuss clinical depression, and learned to identify symptoms of the chronically mentally ill.

Because the responsibilities of the part-time director and the bilingual staff far exceeded their resources during 1986-87, more funds were requested in 1988 through the Federal block grant program to cover the cost of hiring a full-time mental health director and an additional bilingual worker. The state not only provided these funds, but also added funds for a fourth bilingual worker. The monies were granted as part of a matching program; Olmsted County had to agree to match the block grant with an escalating share of the responsibility. In each of three subsequent years, the county would have to supply 10 percent, 30 percent, and 50 percent of the grant.

The county agreed to the match with the stipulation that the Zumbro Valley Community Mental Health Center would take full responsibility for administering the funds in the wake of some financial difficulties at the IMAA. As a result, the program moved to Zumbro Valley CMHC. (It should be noted that this match had been required as part of the initial funding during 1986-87, but Zumbro Valley CMHC requested full first year funding when

services were transferred from the IMAA.) Funds were also supplemented by additional state monies for chemical dependency.

The supply of Federal block grant funds and county cooperation came about through serendipitous circumstances. A national study was conducted in 1987 showing Minnesota as lacking in the provision of mental health services relative to other states. As a result, a new assistant commissioner of Mental Health of the Minnesota Department of Human Services was hired and charged with improving mental health delivery in the state. The block grants were to be made available to "innovative" programs across the state. Moreover, public acceptance of refugees in Rochester and surrounding areas had become jeopardized due to flaring incidents of racism. Olmsted County thus decided to harness its historical commitment to social causes -- particularly the refugees -- and participate in the matching program.

Under the guidance of the new refugee mental health director, Zumbro Valley CMHC began to provide a wider array of services with its expanded staff complement. Social adjustment counseling was provided, with emphases on assessment, screening, and cross-cultural counseling. Home visits as well as referrals were provided where appropriate. Therapy for the more acutely mentally ill was also expanded with extensive screening, and appropriate medication and supervision as needed. In addition, support groups for substance abusers, wives of physically abusive husbands, and abusive husbands were established.

With the expansion of services and the increasing number of referrals to Zumbro Valley CMHC, more staff began to become involved in the effort to serve and treat refugees. The refugee mental health director encouraged all the staff therapists to take on at least one refugee client in order to increase the flexibility and understanding of the entire staff in response to refugee difficulties. Moreover, new avenues of treatment were explored. One innovative therapist skilled in the uses of biofeedback, brought in his own biofeedback machine, trained a bicultural worker in its operation, and began working with refugees. In the second year of the Federal block grant, funds were increased to purchase equipment for the center. Additionally, a grant for interpreters was obtained from the local Mental Health Association. General resources, however, were limited because the county had been unable

to meet its matching requirements for the year. Due to a shortfall in the county budget during the third year, it was able to provide Zumbro CMHC Valley with only 85 percent of the 50 percent matching funds it was scheduled to supply.

4. The Staff Development Issue

As resources are becoming more constrained, fee-for-service reimbursement is gaining importance. Because the staff therapists at Zumbro Valley CMHC are licensed, they may charge the state Medicaid program for services rendered to eligible refugees. Still, a large proportion of services refugees receive are provided by the (unlicensed) bilingual. workers whose services are not reimbursable. As a result, the bilingual workers have been strongly encouraged to enroll in classes to attain the education necessary for licensure.

Because the bilingual workers lack much formal education beyond a high school degree from their native country, the education required -- equivalent to a bachelor's degree -- puts an onerous responsibility on these refugees (as they perceive it). Many expressed the view that their work required 24-hour-a-day attention because the refugee communities from their respective countries looked to them as leaders and helpers who are available for guidance at any time. Neither offers of assistance to obtain scholarships nor time off from work for education have been persuasive in encouraging professional education.

5. Consolidation of Community Support

The expansion and flourishing of New Hope services since 1986 was nourished by the advice, input, and support of various interest groups in Olmsted County. After the initial cooperation with the IMAA, the Zumbro Valley CMHC director helped to establish a Refugee Mental Health Task Force to monitor and facilitate the provision of services to refugees. This task force, set up to meet monthly, includes representatives of most organized groups in Rochester that in any way serve refugees. The organizations represented by Task Force members include the following: the IMAA, the Olmsted County Department of Health, the United States Catholic Council, the Rochester Public School System, and the Olmsted County

Police Department. Communication between the interest groups in Olmsted County remains the most viable avenue to overcoming the funding difficulties New Hope will face.

6. Key Elements

The New Hope program appears to be a successful effort to expand access to mainstream mental health services through the use of bicultural paraprofessional counselors. The program is developing a diverse funding base and appears to be achieving an effective balance between direct bicultural counseling for social adjustment issues and interpretation for mental health therapy by licensed professionals. A troubling resource constraint, however, is the lack of certification for the bicultural staff that would allow for the **more stable funding** support available through Medicaid.

Factors contributing to New Hope's success appear to include the following:

- **Energetic pursuit of funding from various sources, both public and private.** In addition to the grant applications written for Federal block grant funds, the mental health director submitted applications to various agencies requesting programmatic funding. For example, because their Federal mental health grants were too small to support programs in chemical dependency -- a serious problem among some refugees -- funding was procured from the state Chemical Dependency Division. Additionally, because the mental health problems seen in the refugee community were often the concern of other county social service agencies, monies were successfully obtained from the Olmsted County budget.

- **Active networking among providers of services to refugees. The** Refugee Task Force allowed the creation of a regular forum to coordinate efforts between various social service agencies, to identify problem areas where needs were not being met, to discuss new avenues of outreach, and even to address individuals or groups of individuals having unusual difficulties, This forum has been instrumental **in fostering creativity** in joint service provision, encouraging optimism among providers despite resource constraints, and mobilizing other groups to assist more actively in the refugee adjustment process. For instance, Olmsted County Financial Assistance has kept close contact with New Hope providers due to the energy of the Task Force. Moreover, this networking allows for an unusual degree of continuity in the services refugees receive, thus facilitating the adjustment process.

- **Respect for the professional aptitude and judgement of the bicultural paraprofessionals by the refugee community and the licensed American-born professionals.** Because the bicultural workers not only have a central role in providing services at Zumbro Valley CMHC, but also because they are leaders within their communities, they serve as the critical link between the refugees and New Hope. They have the credibility to encourage their compatriots to seek services and the autonomy to keep patients in care. Additionally, as the professionals are gaining appreciation for the perspective of the bicultural workers, they can help to channel clients into new kinds of services (e.g., acupuncture) offered by the paraprofessionals.

B. THE SOUTHEAST ASIAN MENTAL HEALTH UNIT IN FRESNO (Fresno, California)

The Southeast Asian Mental Health Unit is located in the Fresno County Department of Mental Health. Headed by a psychiatric nurse and staffed by several bicultural paraprofessionals, the unit provides case management follow-up, interpretation, counseling, and training services to Hmong, Laotian, Cambodian, and Vietnamese refugees settled in Fresno and the vicinity.

The unit illustrates that sustained efforts by a dedicated advocate on behalf of refugees can result in a commitment of resources in a mainstream mental health agency. The case study further shows that an outreach program can effectively set the stage for utilization of services in a mainstream facility.

1. Mental Health Services in California and Localities

California has one of the largest mental health systems in the country. As of 1985, the state's mental health expenditures were almost $875 million, Approximately 75 percent of mental health revenues were from state sources, with the Federal government and local governments contributing about 10 percent each. California commits a large portion of its funds to community-based services, ranking first in the country in this regard. Its budget for community-based services is higher than its budget for state mental health hospitals.

California's mental health system is highly decentralized. Most of the power and authority is at the county level. Counties have a great deal of discretion in how they define

their priority populations as well as their funding priorities. In Fresno, Mental Health Services is a division within the county Department of Health.

2. The Southeast Asian Mental Health Unit

The Southeast Asian Mental Health Unit provides case management follow-up, interpreting, consulting, and training for refugee clients of the Fresno County Department of Health, Mental Health Services, The unit is comprised of seven bilingual/bicultural paraprofessionals, one Cambodian social worker, one mental health nurse, and a secretary. At least one bicultural paraprofessional represents each ethnic group. The administrator is a psychiatric nurse who has been involved in health service provision for refugees since 1984.

Specific services offered by the unit include:

- **Case management,** including home visits and follow-up for clinic clients, Locating the unit in the case management division of mental health services was undertaken in recognition that much more outreach is needed for the refugee population than for persons in the mainstream culture. A recent addition is a focus on youth mental health needs via a position contributed by the Adolescent Service Division of the Mental Health Department.

- Interpretation by bicultural staff for therapy sessions conducted by licensed clinicians. An attempt is made to educate clinicians about Southeast Asian cultures, The unit has also organized a 24-hour interpreter pool which can be tapped, for example, at the hospital emergency room.

- **Support groups,** including groups for the various nationalities seen by the staff. These groups are run by the unit staff. Currently there is a Cambodian women's case management group, a community Hmong seniors support group, and a Lao women's outpatient group.

- **Consultation and training** are offered as requested and through weekly meetings with department mental health practitioners. Outside consultation is also provided to a community-based critical needs project (through Lao Family Services) which offers interpretation, referral, and traditional family-based counseling.

The one-time funds which started the program resulted from county mental health savings in one fiscal year that were then "rolled over" to the next. Each year since 1988, roll-

over monies have funded the unit. In addition, the resource base has become broader and more stable since the case management services were recently made eligible-for Medicaid funding. (For further discussion of this issue, see Part Ill.)

3. Origin and Development of the Service

As in a number of California's rural counties which experienced large influxes of Southeast Asian refugees during the 1980s, the Mental Health Services division of the Fresno Health Department was a late comer to providing services to this population. The schools, police, and social service departments were affected much more immediately. By 1984, however, refugees were beginning to appear at the county mental health clinics and psychiatric inpatient hospitals.

Services for refugees have taken a number of forms starting in 1984. Early that year, the Health Department identified mental health staff interested in working with refugees and developed an informal consultation group. One administrative staff person was asked to coordinate available services within the department, which consisted of two interpreter trainees from a local MAA and an Asian-American mental health nurse/therapist who was handling most of the outpatient refugee caseload.

More extensive services began later in 1984 when the County's Department of Social Services proposed using Title XX funds to develop a three year health promotion/outreach demonstration project targeted at the Hmong population. **The Hmong are the largest and most culturally different of the Southeast Asian groups within Fresno** County. Key staff within the Department of Health were instrumental in developing this project with input from refugee community leaders and practitioners who were already involved in the provision of services within the Department. The Department of Health contributed three "in-kind" staff persons called technical outreach workers: a mental health nurse, a public health nurse, and an environmental health specialist. These persons were combined with a social worker from the Department of Social Services to form an outreach team. As the project got underway, Lao and Cambodian populations were also targeted.

The multi-disciplinary model was innovative and successful. The Lao Family Community, a local mutual assistance association, was contracted with to administer the project and recruit five bicultural paraprofessionals. One of the paraprofessional staff was designated as lead worker, a position that later was changed to a supervising position. The Health Department professionals provided technical expertise and leadership for the project.

A steering committee included members of all of the refugee groups. Steering committee members were paid small stipends and helped the project by doing some interpretation, organization, community meetings, and in general provided legitimacy to the project. Other steering committee members included representatives of the key service agencies, including the Department of Social Services and Department of Health.

The project used a health promotion model to deal with mental health (stress and adjustment problems), physical health, and such environmental issues as food handling, roaches, gas leakage, sanitation, and farm animals within city limits. The project focused on the recruitment and training of natural helper volunteers within apartment complexes where refugees were concentrated. Volunteers chosen by those living in the respective apartment complexes would assist in setting up community meetings, apartment complex training, and referral of persons with mental health or environmental health problems into the program. The volunteers received monthly training from the project paraprofessionals and the Health Department in-kind staff. This monthly training encompassed a range of mental health, environmental health, and physical health areas.

The project used this outreach model between 1985 and 1988. The outreach program continues now but with reduced staffing and no mental health component. In the meantime however, the Southeast Asian Mental Health Unit was established within the Department of Health. This bicultural mental health unit grew from efforts of the psychiatric nurse working on the outreach pilot project, who proposed as early as 1986 that a bicultural mental health team be developed to ensure long-term availability of services for refugees. It was not until 1988 that such a program was established with Health Department funds,

In retrospect, four critical factors seem to have contributed to the eventual funding of the Southeast Asian Unit:

- Growing support by advocacy organizations/agencies and key administrative staff within the Health Department.
- Findings from a Southeast Asian refugee mental health needs assessment study which were presented to key administrative staff and decision-makers. This needs assessment was financed through the California RAP-MH initiative (See Part I.).
- Reorganization of the Fresno mental health system with increased organizational stability.
- Increased revenues made available to the Department due to increased efficiency in billing and a new payment rate negotiated with the State Department of Mental Health. Fresno Health Department planning included an initiative for Southeast Asian Mental Health Services at the time these funds became available.

4. Key Elements

The Fresno County Health Department unit has clearly increased the availability of mental health services for refugees. Placement of these services in the County unit has had some negative ramifications, however. The County emphasis on services for the severely impaired (a trend found in many other localities) has meant reduction in outreach and prevention efforts. Thus the multi-disciplinary outreach approach that preceded the current bicultural unit no longer includes a mental health component.

Some of the key elements contributing to the successful establishment of both the outreach program and the newer bicultural unit are as follows:

- **Emphasis on Outreach.** Having had a program focused on outreach meant that steps were taken to identify people in need of services and to make refugees more willing to utilize the service system. This was especially evident when the public health outreach team had a mental health component. Because of the multi-disciplinary nature of the outreach team, clients viewed their assistance not as a stigmatized mental health program, but as a full set of public health-related services,

- **Linkages with organizations that were adversely affected by refugee mental health problems.** Responsiveness of the mental health system to refugee needs in Fresno was largely a function of pressure from professionals in systems which were impacted by refugees earlier, particularly school and welfare systems. These departments later became powerful allies in advocacy efforts for mental health services for refugees,

- **The leadership and persistence of various advocates combined with effective use of information on refugee needs.** The psychiatric nurse, in particular, was persistent in pressing for culturally sensitive services, along with other professionals and representatives of the refugee community. Apparently, key administrators and decision-makers were also influenced by information on refugee mental health needs made available through the RAP-MH-sponsored Southeast Asian refugee needs assessment.

- **Training efforts** aimed at both the paraprofessional bicultural staff and American-born professionals in the Department. Paraprofessionals receive weekly in-service training. Mental health professionals, particularly those involved in the outreach program, received extensive exposure to the culture, needs, and perspectives of the Hmong, Lao, and Cambodian populations:

- **Emphasis on a broad array of refugee needs,** including follow-up care, home visits, support groups, and interpretation. Like several of the other programs in this handbook, the public health outreach team and the mental health unit recognized that the needs of refugees are more complex than characterized by a purely therapeutic approach.

C. BILINGUAL REFUGEE SERVICES IN THE DR. HARRY C. SOLOMON MENTAL HEALTH CENTER (Lowell, Massachusetts)

The Dr. Harry C. Solomon Mental Health Center has a bicultural case manager to assist with Cambodian clients at several points in the local mental health system including intake and orientation, supportive clinical therapy, emergency services, and inpatient mental health services. The Solomon Mental Health Center is located in Lowell, Massachusetts. The bicultural worker was hired to help American-born therapists respond to the needs of a rapidly growing Cambodian population. While relatively few Cambodians were making use of the Center during the influx of refugees into the community, the state RAP-MH staff (Refugee Assistance Program-Mental Health; see Part I) and other community advocates for refugees saw the need for cultural sensitivity and advocated for enhanced staffing at the Center.

These advocacy efforts converged with the Center's own efforts to cope with the growing needs of refugees.

The experience in Lowell illustrates the potential for gradual but important change in a mainstream mental health center facilitated by advocacy within the state mental health system. The Massachusetts RAP-MH staff (and other advocates) made a concerted effort to demonstrate the need for bicultural capacity at the Center, and worked with leadership and staff at the center to hire the worker under new state fiscal authority for Medicaid case manager positions. The center hopes to expand services on behalf of refugees in Lowell although the current Massachusetts fiscal crisis has made new efforts unlikely.

1. The Mental Health System in Massachusetts and Lowell

In Lowell, the Solomon Mental Health Center is part of a comprehensive mental health system. Solomon has a 46-bed inpatient mental health unit, emergency mental health services, as well as several outpatient services. The Center contracts with service providers to offer a full range of contracted services in the community. The Center is the major public source of outpatient mental health care in the Greater Lowell Community of about 240,000 persons.

Total staff at the Center number about 160 persons including psychiatrists, psychologists, psychiatric nurses, social workers, and paraprofessional case managers, as well as clerical and support staff. The Center provides comprehensive mental health services for a wide range of mental health conditions, most of them severe to moderate in nature. Staff at the Center also provided care, consultation, and follow-up for patients of the neighboring inpatient unit, as well as outreach and home visits. Of the $7.5 million annual budget for FY 91 at the Center, about 76 percent comes from state appropriation, and the balance of 24 percent comes from Medicaid, Medicare, and other third-party payers.

2. Bicultural Capacity at the Solomon Center

Of the two paraprofessional case managers at the Center, one is a bilingual Cambodian who has been with the staff for almost two years. He serves Cambodian and other patients who are severely mentally ill and who have entered the system through emergency services, the inpatient unit, or (less commonly) through direct contact with the Community Mental Health Center.

"Case managers" are a new position in the Massachusetts mental health system, emerging out of a 1987 Governor's initiative to improve and expand mental health services statewide. One of the funding sources used by the Governor was the relatively new Federal Medicaid option known as "targeted case management." Massachusetts has traditionally been effective at maximizing Medicaid funding as a way of tapping Federal dollars. As described in more detail in Part III of this handbook, state Medicaid spending is matched at a rate of 50 percent or more by the Federal government. The new case management function allows states to claim Medicaid reimbursement for services aimed at helping mental health clients access a range of services related to their mental health needs, including psychiatric therapy, physical health care, cash and medical assistance, and a variety of other social services.

In this position, the Cambodian worker deals directly with clients and clinicians on a range of supportive services including:

- Development of a treatment plan including not only expected clinical therapy but also goals and expectations for other kinds of services and supports.
- Interpretation and assistance in therapy sessions (although, as a Medicaid case manager, he is not allowed to provide direct counseling or therapy).
- Assistance to clients in obtaining supportive services, such as helping them make medical appointments, assistance with applications for cash and medical assistance, and referral to social and housing services. This often entails transporting clients to appointments and serving as interpreter.
- Discharge planning for patients in the inpatient unit.

- Assistance with emergency room evaluations, including interpretation and consultation with professional staff.
- Interpretation on behalf of patients on the Inpatient Unit.

The bicultural worker has also offered more general guidance and advice to professional staff at the Center on the refugee experience and the mental health needs of Cambodians, This included a slide presentation on his own experience as a refugee.

3. Origin and Development of Bicultural Capacity at the Center

The need for culturally sensitive mental health services in Lowell came with the dramatic influx of Cambodians during the latter half of the 1980s. In the course of two to three years, the refugee population grew from a few thousand to an estimated 25,000. Service providers were increasingly concerned about the number of refugees they were seeing -- particularly widows and older refugees -- who were depressed, withdrawn, experiencing intergenerational conflicts, or showing signs of more severe psychological trauma.

Few Cambodians were initially seen at the Solomon Mental Health Center. Severe mental health cases coming through the emergency department were either hospitalized or referred to the Indochinese Psychiatric Center (IPC), a specialty clinic near Boston that was becoming well known and highly regarded for its work with refugees. Most observers felt, however, that other Cambodians in need were avoiding the Solomon Mental Health Center, both because of stigma associated with American mental health care and because of the intimidating nature of the therapeutic setting. Because there were no Cambodians or bilingual capacity at the Center, a potential client would have to face tremendous communication problems as well as the confusion and fear that comes with a strange American system.

This service need was recognized by RAP-MH staff in the Department of Mental Health as well as other refugee advocates in the state. Staff from Metropolitan Indochinese Children and Adolescent Services (MICAS) (see case study in Chapter Four) approached the

Solomon Center (which is also the DMH Area Office) for funding to establish contracted mental health counselors in the schools. At the same time, the RAP-MH staff- began making the case for refugee capacity at the Center. They conducted a series of discussions and informational meetings with the Area Office Director and with senior staff at the Solomon Center, explaining to them the likely severity of unmet and largely hidden need in the rapidly burgeoning community. While recognizing that there were no Cambodian mental health or social work professionals available in the state, the RAP-MH office suggested the use of bicultural paraprofessional staff. The Massachusetts Association of Mental Health also became involved in these advocacy efforts.

These discussions with advocacy groups converged with Center staff's growing recognition of the need for special staffing and their own efforts to meet the needs of Cambodian clients. Until this time, Solomon staff were responding to the needs of Cambodians that did come to the center through a combination of referrals and related supports. Considerable staff time was devoted, for example, to accompanying Cambodian patients to the IPC and working with them on follow-up visits. Initially, however, funding constraints made it difficult for administrative staff at the Solomon Center to earmark dollars for bicultural capacity. The Director began by setting aside funds for the MICAS workers, but he was initially reluctant to commit limited funding dollars for a staff position to a bicultural worker. This was before Massachusetts instituted the case management function, so he was faced with having to commit an existing professional slot.

With the Governor's funding initiative in early 1988, however, the Director decided he could designate one of the new case manager positions for a bicultural worker. Selection of the worker was accomplished through a committee comprised of professional staff from the Solomon Center, RAP-MH staff, and representatives of the refugee community. Before the committee was formed, however, the Center made a preliminary decision on a job candidate who had appealing mental health credentials and an Associate degree, but did not have credibility within much of the Cambodian community. This prompted the formation of the committee, a step that was encouraged by the RAP-MH Office and others involved in the advocacy process. Eventually, all involved parties agreed that a candidate with closer connections to the community was preferable.

In his two years at the Center, the bicultural worker has apparently proved his worth to the professional staff, some of whom were unsure of his role initially: His role as interpreter and coordinator are now well regarded and appreciated, and staff at the Center are beginning to see the tremendous unmet need that still exists in the community,

While the Center now sees several Cambodian patients, Solomon and Area Office administrators have concluded that a more comprehensive approach is needed. Instead of the supplementary coordinating role now played by the bicultural worker, they would like to see a fully staffed outreach and counseling function designed to reach refugees in their homes, They are also discussing ways to involve bicultural staff more in a team therapy model as is currently in place at the Lynn Community Health Center (see Chapter Two) and other programs in Massachusetts. The likelihood of significant expansion is highly uncertain, however, because of the budget crisis currently facing Massachusetts.

4. Key Elements

The effort by the RAP-MH program and other advocates in Massachusetts has facilitated improved services for refugees in Lowell. Advocacy efforts on behalf of the Cambodian population converged with a growing recognition by Solomon Center staff that enhanced service capacity was needed. While the Solomon Mental Health Center does not have the well-developed services for refugees evident in some of the other programs in this handbook, there is now a staff person who can help Cambodians negotiate the American system and who can intervene as interpreter and helper in the therapy process.

Factors contributing to progress at the Solomon Center include the following:

- **Focused, locally directed efforts of the RAP-MH office.** Unlike a number of other PAP-MH programs, the Massachusetts effort selected an area with need and focussed considerable energy in educating and convincing key actors to add bicultural capacity. This initial, modest investment of a single bicultural worker is now paying off. Center staff are seeing the value of bilingual assistance and have become very supportive of the case manager function with time. In the meantime, advocates have continued to demonstrate unmet need in the community. While funding in Massachusetts is extremely tight, the case manager position and these newly committed funds appear to be secure

and the philosophical commitment is unlikely to wane even if further expansion is currently unthinkable.

- **Efforts to educate American-born professional staff** have reportedly been effective. The bicultural worker apparently enhanced his credibility among the professional staff when he conducted a presentation on his refugee experience. As a result of this and general interaction with the worker, professional staff are now much more aware of the hardships ensured by refugees and of their cultural and mental health needs. One therapist described an "evolution of thinking" that has occurred as she and others have recognized needs and appropriate responses to a population that was unknown to them only a short time ago.

- **Reliance on Medicaid financing,** particularly through the targeted case management option. As discussed in Part III, states can fund positions such as this one through Medicaid for purposes of coordinating and assisting patients with access to services. The case manager cannot, however, conduct outreach (i.e., home visits) or "hands on" therapy, both approaches that the Center may want to attempt in the future.

- **Level of trust accorded the bicultural worker by the refugee community, a** trust that may not have developed had the Center not sought out input from local refugee leaders.

CHAPTER TWO:
REFUGEE MENTAL HEALTH SERVICES IN A MEDICAL HEALTH CARE SETTING

Some mental health programs for refugees (and for other populations) are located in medical health care settings. Administrators of these programs point to two important advantages of this arrangement. First, service providers can address the interactions between physical and mental health. Refugees (and other populations) often seek help for a somatic condition rather than causal or contributory mental health problems. When the services are co-located, physicians can make appropriate referrals to mental health workers and vice versa.

Second, physical health settings can reduce the stigma associated with seeking help. In many cultures, great stigma is attached to admitting that a family member is experiencing mental health problems. Despite mental distress, it is not easy for Southeast Asian refugees to seek psychiatric help simply because of traditional Asian attitudes towards the mentally ill which include fear, rejection, and ridicule, and the concern that the presence of a mentally ill person in the family will affect the family's social and economic status, Location in a health clinic can help overcome this stigma by de-emphasizing mental health therapy as a separate and distinct service.

This chapter describes three programs that are located in a medical care setting:

- The Southeast Asian Services in the Lynn Community Health Center (Lynn, MA);
- The Southeast Asian Mental Health and Social Adjustment Program at the Community University Health Care Clinic (Minneapolis, MN); and
- The Southeast Asian Support Center at St. Joseph's Hospital (Providence, Rhode Island).

A. SOUTHEAST ASIAN SERVICES IN THE LYNN COMMUNITY HEALTH CENTER (Lynn, Massachusetts)

Mental health services for Southeast Asians have been available at the Lynn Community Health Center since 1987. The Center is a not-for-profit, outpatient primary care

facility in a community of 80,000 persons about 12 miles northeast of Boston. The Center relies on a mixture of Federal, state, and private financing. The Southeast Asian program is staffed by an American-born psychiatric nurse and two Cambodian paraprofessionals. They use a team approach with clinical staff at the Center and a consulting psychiatrist who specializes in Cambodian therapy. The program has approximately 50 active cases, most of which are Cambodians with moderate to severe mental disorders.

The program at the Lynn Center illustrates the potential for reducing the stigma associated with mental health services by linking psychiatric support with primary health care. Also contributing to the center's success is its emphasis on home visits and its response to the multi-faceted problems facing many refugees,

1. Mental Health Services in Massachusetts and Lynn

The Massachusetts Department of Mental Health (DMH) administers the state's system of inpatient and outpatient mental health services. General funding and programmatic decisions are made at the state level, with regional and area offices responsible for designing service approaches for their communities. Like many states, Massachusetts recently moved to an emphasis on the "chronically and seriously mentally ill" as the priority population for funding.

The local DMH office in Lynn offers limited direct outpatient care, relying largely on contract providers instead. The community hospital provided most outpatient services for the uninsured until 1987 when the contract was shifted to Tri-City Mental Health, a not-for-profit mental health facility.

Because Massachusetts is undergoing a severe financial crisis, funding for mental health and other social services is constrained. Serious cutbacks are expected. Prior to this time, however, the state had a relatively healthy budget and had expanded mental health initiatives in a number of programmatic areas.

While Lynn has had some Vietnamese and Cambodian residents since about 1980, the last five years has seen a dramatic influx of Cambodians bringing the total Southeast Asian population to about 8 percent of the 80,000 Lynn residents. Hispanics account for another 12 percent. The service and educational infrastructure in Lynn has had to adapt to these changing demographics, including the health and mental health system. Employment opportunities for the new immigrants come from the town's factory-based economy, although many continue to rely partly or exclusively on public assistance.

2. Lynn Community Health Center

The setting for the Southeast Asian program is Lynn Community Health Center, a 501 (C)3 non-profit, outpatient primary care facility incorporated in 1972. Partially supported with Federal funds from Section 330 of the Public Health Service Act, the mission of the Center is to provide access to primary health services for persons facing barriers to care **such as lack of insurance, inadequate income, limited English, and cultural background.** The Center is a major source of outpatient services **for much of Lynn's low income population.**

Services provided by the Center include adult medicine, gerontology, pediatrics, adolescent health, obstetrics, gynecology, family planning, social services, clinical nutrition, WIC (Women, Infants, and Children Nutritional Program), health education, and laboratory services. The Center also offers mental health services. While the Federal Section 330 funds do not support the mental health services, the Center has contracts from the Lynn DMH office to offer minority mental health services to Hispanics and Southeast Asians. When combined with third-party payments, other state funds, and foundation grants, these sources combine to support mental health services to non-minority patients as well as the two linguistic groups,

In 1989, the Center had a total budget of $2.6 million, about half of which was derived from patient revenues from insurance, Medicaid, Medicare, or direct payments on a sliding fee scale. Another third was from state contracts, and most of the remainder was comprised of Federal Section 330 funds. About $600,000 of the budget is for mental health services, $125,000 of which is a DMH grant to service Southeast Asian refugees.

The Center had over 401,000 patient encounters in 1989, 12,000 of which were for mental health services. The Center is staffed by about 85 Full-Time-Equivalents (FTEs), 22 of whom provide mental health services. The latter include psychiatrists, Ph.D. psychologists, one psychiatric nurse, MSW social workers, and paraprofessional case managers,

3. The Southeast Asian Program

Of the mental health staff described above, a psychiatric nurse and two Cambodian paraprofessionals (one of whom was a physician in Cambodia) are the core staff for Southeast Asian services. These three persons work on a team basis with other professional staff at the Center and a consulting psychiatrist who specializes in therapy for Southeast Asians, (The latter staff person directs the Indochinese Psychiatric Center, a specialized refugee mental health clinic located in the Boston area.)

The Southeast Asian program has an active caseload of about 50 primarily Cambodian refugees. included in this group is a support and therapy group for 12 Cambodian women, which meets weekly. Care is generally for severe to moderate mental health conditions, including Major Affective Depression, Post-Traumatic Stress Syndrome, organic brain disorders, substance abuse, and minor adjustment disorders.

The Southeast Asian service staff uses a multi-faceted or “holistic” service approach. Paraprofessional counseling and clinical therapy are supplemented with efforts to address other barriers to wellness such as financial and housing problems, cultural adjustment issues, intergenerational conflicts, and other stresses associated with adjustment to a new life. The staff view as integral to their therapeutic approach such activities as driving a refugee to a social services office, helping a home-bound widow deal with a housing or utilities dispute, or explaining the American school system to a parent who is distressed by a child’s activities in the classroom. Therapy is also closely coordinated with physical health services in the Center, often the entry point for mental health care for patients with somatic conditions.

Referrals to Southeast Asian services come from several sources, including physicians at the center who suspect somatic conditions, refugee service agencies, mainstream service agencies, schools, family members, and friends. Referrals by and coordination with the medical staff are facilitated by a full-time Cambodian interpreter.

The primary mode of service delivery is through home visits by one of the Cambodian paraprofessionals. Four days a week, she counsels patients and prospective patients in the home, responding to reports of need from family members, neighbors, schools, and other sources in the refugee community. These home visits are a key ingredient of program success for two important reasons:

- They enable the counselor to observe the contextual factors contributing to (or resulting from) mental health problems, such as signs of spouse or child abuse, intergenerational conflicts, or inadequate housing conditions.
- Many refugees in need are reluctant to come to the Center for a number of reasons, including fear of stigmatization, inability or refusal to see a need, and reluctance to use a Western service system. By conducting home visits, the paraprofessional can establish a level of trust with the client, suggesting after a number of visits (if appropriate) that the client come to ttie Center to obtain medication and professional therapy from a physician. Frequently, the initial attraction to the Center is the hope of physical relief from a somatic condition (e.g., chronic headache). Once the patient becomes accustomed to the Center, many then **agree to more** extensive clinical therapy.

Therapy at the center is a combination of group and individual sessions. The Cambodian widows group meets once a week, and the American-born psychiatric nurse runs the sessions jointly with a Cambodian paraprofessional. A “give-and-take” process is used by the two staff members, sometimes with the Cambodian working directly and in her own language with the women and sometimes with the nurse directing discussion through the Cambodian paraprofessional.

Individual therapy is usually conducted by a team comprised of a professional staff member and one or more of the Cambodian workers. The team conducts counseling jointly, with considerable case consultation before and after formal sessions.

4. Origin and Development of the Service

Southeast Asian Services at the Lynn Community Health Center were founded in the Summer of 1987 in response to a Request for Proposal (RFP) from the local DMH office for services to linguistic minorities. DMH was receiving increasing numbers of Hispanic and Southeast Asian referrals for whom it was not equipped. At the time, the Lynn community hospital had the DMH contract for outpatient therapy, but was ill-equipped to deal with the cultural and language differences of the two populations,

DMH recognized that bicultural professional workers were scarce, and that a reasonable service model would involve bicultural paraprofessionals working in concert with clinical staff. Because Medicaid reimbursement is only available to licensed professionals, however, providing services would have entailed direct financial support from state funds. DMH asked for proposals at a funding level of $125,000 for Southeast Asians and Hispanics.

Lynn Community Health Center was well-positioned to develop a Southeast Asian program in response to the RFP. The Center already had part-time Cambodian translators for both physical and mental health services. Additionally, the Center director had previously worked at the South Cove Community Health Center which already had well-developed services for refugees and had spawned the Metropolitan Indochinese Children and Adolescent Services (MICAS) (see case study in Chapter Four).

Lynn Community Health Center obtained the three-year grant at $125,000 per year, and hired its first full-time paraprofessional worker in the spring of 1987. This Cambodian worked with the Director and the mental health director to develop the program, and then left the center to work full-time in a psychiatry residency at Cambridge City Hospital. (It is hoped he will return to the Center once he completes the residency.) The two current Cambodian paraprofessionals were hired in 1988 and continue to serve as the core of the program.

DMH has been pleased with the Center program and the administration of the grant funds. The favorable assessment comes in part from the efficient and effective approach to use of funds by the Center. The funds are kept in an account as “payer of last

resort," and are used only to pay for services not covered by Medicaid or other third-party reimbursement. All staff in the program keep careful records of their time, with licensed staff time spent in therapy charged to third-party payers, and paraprofessional staff time and uncovered professional staff time charged to the fund account.

Currently, the Lynn Southeast Asian program is confronting a funding cutback due to the statewide budget crisis. DMH has reduced the current (third year) contract amount (along with other outpatient menta! health services in Lynn), leaving the program with only a few months of financing. The Director hopes to obtain replacement funding from the city or other sources but foresees an uphill battle. She has been raising awareness by describing the program in public presentations, but realizes that Lynn is a conservative community in which too much attention on the mental health needs of refugees could reduce rather than increase funding potential. Her plan is to continue with "quiet politicking" at the state and local level.

5. Key Elements

The Southeast Asian program at the Lynn Center appears to have developed a successful team approach to mental health counseling for refugees, drawing on the strengths of both bicultural staff and American-born professionals. State financial constraints, however, are likely to heighten the need for finding professionally trained bicultural workers for whom Medicaid reimbursement can be obtained. Among factors contributing to the success of the program appear to be the following:

- Recognition **of refugee mental health** needs by the public mental health system, a level of understanding not always present in these situations, was instrumental in OMH's decision to make funding available.

- **Multi-faceted service supports.** Program staff repot-t that the effectiveness of the mental health. care. is considerably enhanced by concurrent attention to other barriers to wellness, such as housing, financial needs, and cultural adjustment counseling. Treating the client "holistically" helps to reduce the stigma associated with traditional psychiatric care. The service is not called a "mental health clinic," and the patients reportedly see themselves not as psychiatric patients in a clinic for "crazy people," but as clients of a primary

health care center which includes general counseling and support from a Cambodian counselor.

- **Home visits** as a primary service mode have allowed the bicultural workers to: (a) assess mental health needs in the context of the refugee's family and living situation; (b) develop a trust level with the patient in a comfortable environment before encouraging them to obtain professional assistance; and (c) avoid the potential stigma of institution-based care.

- **Integration with physical health services in** a primary care setting which clearly enhances access to and effectiveness of mental health services. This integration is particularly important for refugees who may have somatic conditions and are more comfortable with the Western medical practices than with the concept of mental illness. Stigma associated with the clinic is reportedly low because of its major focus on physical health care. Primary care providers at the Center are able to refer refugees into the mental health program as one more form of treatment for their physical ailments rather than a separate institution for which a user is seen to be an acknowledged "crazy person." Moreover, the Southeast Asian staff is able to move refugees into therapy gradually, beginning with a physical health exam and symptom-treating medication,

- **Team approach and atmosphere of mutual respect among professional and paraprofessional staff.** The professional staff at the Center apparently have accepted the bicultural workers as partners in providing therapy rather than as simple interpreters. This mutually supportive atmosphere has been cultivated by senior Center staff who believe that the bilinguals' understanding of culture, language, and the refugee experience should be an integrated part of the therapeutic protocol. Moreover, the professional staff appears to recognize how helpful the bicultural staff can be in helping them understand the refugee experience and cultural context for mental health problems.

- Support for professional development **and autonomy of bicultural staff.** The Director of the Center and of the Southeast Asian program have given the bicultural workers considerable autonomy in designing and carrying out the outreach and home visiting components of the program. Continuing education for these staff is encouraged (and paid for if worked-related) and the team therapy approach encourages considerable "on-the job" training in mental health issues. The Center Director feels that this support for professional development was critical in her ability to recruit competent staff.

- **Acceptance and respect of the bicultural staff by the refugee community.** It has apparently been critical that the Cambodians are respected and trusted members of their community, allowing them to enter homes without suspicion or fear, and helping them convince patients of the need for medication, therapy, and other supports.

- **Maximization of Medicaid and other third-party payments,** a strategy made explicit by establishing the grant funds as a "payer of last resort" and requiring Center staff to track services for purposes of Medicaid reimbursement.

B. REFUGEE MENTAL HEALTH SERVICES AT THE COMMUNITY UNIVERSITY HEALTH CARE CENTER (CUHCC) (Minneapolis, Minnesota)

The Southeast Asian Mental Health and Social Adjustment program is housed within the Community University Health Care Center (CUHCC) in Minneapolis. This university-supported clinic offers low-cost health services to the low income residents of a neighborhood comprised mainly of Caucasians, Southeast Asians, and Native Americans. Mental health supports for refugees are supplied through a team approach involving eight bicultural staff, nine American-born social workers, and three American-born psychiatric professionals.

The refugee service at CUHCC illustrates the potential for supplementing clinic health services with bicultural psychiatric support. Southeast Asians have found care at CUHCC for various physical maladies since they first came in large numbers to the Minneapolis area in the late 1970s. Over time, however, the staff at CUHCC recognized that many of these refugees, like their American counterparts, had psychological problems as well. Because CUHCC houses mental health facilities at the same location, it is in a unique position to offer mental health assistance to these refugees in a non-threatening manner.

1. Mental Health Services In Minnesota and Minneapolis

As discussed in the previous chapter, public mental health services in Minnesota are largely decentralized. The state mental health agency makes general funding and programmatic decisions, but the counties provide a substantial share of the funding and are responsible for designing service approaches for their communities. The Hennepin County (Minneapolis) Division of Mental Health relies extensively on contracts with service agencies such as CUHCC.

2. The Community University Health Care Center (CUHCC)

The Community University Health Care Center (CUHCC) in Minneapolis, Minnesota, is a health care clinic serving the many needy who live in the poor neighborhoods in its immediate vicinity. The 25-year-old clinic was originally founded by the University of Minnesota as a youth health care project for low-income children in geographically underserved areas. The clinic was soon expanded to treat family health problems as well. On its first two floors, the clinic provides various physical health services to its clients. The third floor houses a mental health unit. These facilities were able to serve a caseload of approximately 5,000 patients in 1989 on a budget of approximately $2.1 million; 1,500 of the clients were receiving mental health treatment. The clients CUHCC serves come from a variety of backgrounds, including 44 percent Caucasians, 34 percent Southeast Asians, 15 percent Native Americans, 5 percent African-Americans, 1 percent Hispanics, and 1 percent other ethnic groups. The largest group of Southeast Asians are Hmong, followed by Lao, Vietnamese, and Cambodian.

3. **The Southeast Asian Mental Health and Social Adjustment Program**

Within the mental health department at CUHCC are special services for the Southeast Asians that comprise almost a third of the caseload. Staffing takes advantage of American-born professional and refugee paraprofessional teams. Currently, three psychiatric professional FTEs supervise nine social worker FTEs and eight bicultural staff. Four are of Hmong origin, two are ethnic Lao, one is Vietnamese, and one is Cambodian. They assist in many services designed to address mental illness, social adjustment, and family therapy needs including: psychiatric and psychological assessment for Post-Traumatic Stress Disorder, depression, schizophrenia, psychosomatic diseases, and adjustment disorders. They also help with medication monitoring; individual, family, and group counseling; acupuncture; and referrals as appropriate.

The table below details complicating case characteristics among refugees served in 1989 (some clients appear in more than one category):

Case Characteristic	Number Treated
Limited English Speaking	400
Dangerous to Others, Self	77
Chronically Mentally Ill	43
Battering/Family Violence Victim	40
Inpatient Treatment Required	24
Chemical Dependence	18
Sexual Assault Victim	16
Special Education Needed	15
Family Member with Chemical Dependence	14
Child Abuse Victim	11
In Residential Treatment (not hospital)	1
TOTAL	580

Care rendered to refugees is provided primarily through a team effort. A member of the bilingual staff will be the first contact a refugee has within CUHCC. This paraprofessional will make an assessment of services the refugee will need. Should the client need mental illness therapy and medication monitoring, the professional and paraprofessionals will alternate sessions with the refugee. If social adjustment services are required, the bicultural worker will assemble a client-specific care plan with the consultation of a professional. Though the bicultural staff are guided throughout the patient's care by American professionals, they are mostly autonomous in their rendering of these services. In some cases, many of the services provided are actually rendered within the refugee community itself. that is, in refugee homes or social meeting places. Finally, should family counseling be needed, joint counseling/interpretation is provided by the professional and the paraprofessional.

The model for providing care at the Southeast Asian Mental Health and Social Adjustment Program is based on the understanding that the bicultural mental health workers are in a strong position to assist actively in the social adjustment process because they themselves'are successfully mastering it. Furthermore, because they have credibility and standing in the refugee community, their one-on-one counseling can reach the refugees in a manner American-born professionals cannot emulate. This approach stands in contrast to a professional-oriented model where the bilingual workers are regarded as translators, without

an active role in care-giving. Though conflict occasionally arises between the bicultural and the American-born staff due to competition and a lack of understanding, this consulting relationship has reportedly been beneficial **for the refugees seeking help.**

4. Origins and Development of the Southeast Asian Program

The history of the Southeast Asian program at CUHCC began in the early 1980s when a social worker and a psychiatric resident began to address the mental health problems of the refugees. After securing a grant from the Minneapolis Foundation (an active local foundation), they initiated refugee-specific mental health services with interpreting assistance from a bilingual worker. Subsequently, the need for more services became quickly apparent and CUHCC established the Southeast Asian Mental Health and Social Adjustment Program and began outreach efforts. Before the foundation funds were depleted, CUHCC appealed to the county (mainstream) mental health system for ongoing financial assistance to address the unmet mental health needs of refugees. Due to the activism of county officials as well as public commitment to assisting the refugees, CUHCC has continued to receive these grant funds annually (though not without controversy).

Funding for Southeast Asians became more diversified beginning in 1987. In that year, a group of Southeast Asian women at the Minneapolis Mutual Assistance Association was approached by the Minneapolis Department of Corrections to provide support services to victims of spouse abuse (primarily women). After nine months of difficulties (including death threats from the refugee community if services were continued), the MAA returned the funding to the Department of Corrections. At this juncture, the Department turned to CUHCC. CUHCC agreed to assume responsibility for provision of counseling services on the condition that the Department allow for a six-month period during which CUHCC could raise awareness, generate discussion in the refugee community -- as well as in the Minneapolis mental health community -- regarding spouse abuse issues, and, importantly, gain credibility with refugee leaders. After successfully persuading the refugee community that the objective of their program was to help keep people safe and to maintain the integrity of the refugee family in a difficult environment, CUHCC experienced a sharply increased demand for mental health services among refugees.

In the wake of this experience, CUHCC began to apply for funding from various other agencies to expand their services. In particular, grants were received from the state Health and Human Services Agency for services in sexual assault counseling, spouse abuse counseling, chemical dependency prevention, and child abuse counseling and prevention. Monies from the state refugee office (Refugee Immigrant and Assistance Division -- RIAD) were also made available to provide mental health and social adjustment services. Hennepin (Minneapolis) County's mainstream Division of Mental Health also supplied substantial funding to CUHCC upon recommendations from a county Minority Mental Health Advisory Committee (the local task force on minority mental health). Other funding sources for various services included foundation grants, the Minneapolis Public Schools, the Hennepin County Department of Corrections (providing Federal pass-through dollars for victims of violent crime), and United Way.

5. Professional Development of Bicultural Staff

It has been a primary goal of administrators at CUHCC to encourage advanced education for the bicultural workers in order to make them eligible for Medical Assistance (Medicaid) reimbursement. One Vietnamese woman did receive a Master's degree in social work, but she has since left. CUHCC is in the fortunate situation of affiliation with the University of Minnesota and can thus offer scholarships. As a result, a number of refugees have chosen to initiate studies, but, with the exception of one Vietnamese man to receive certification in chemical dependency and the Vietnamese woman previously noted, progress has been slow.

6. Key Elements

Refugee mental health services at CUHCC have successfully drawn on the concept of team therapy, relying on both bicultural and American-born staff within the center. A program with modest beginnings, the effort has grown through diversified funding sources into a substantial and relatively stable source of assistance for refugees. As with similar programs, the absence of professionally trained bicultural staff has hindered the ability of the Center to obtain Medicaid financing, but Center staff have compensated by tapping into grant

and contract funds available for many of the special needs faced by refugees. Among factors contributing to the apparent effectiveness of the Center are the following:

- **Co-location of physical health services** has encouraged the utilization of mental health services among clients. Because physical health providers can refer clients "upstairs," the reluctance to approach a mental health provider is minimized. Furthermore, long-term compliance can be enhanced due to the increased ability of different practitioners to communicate with one another regarding individual cases.

- **Coordination with the refugee community to gain approval** has helped to ensure that CUHCC's services are utilized. Because CUHCC worked with the leaders of the refugee community in explaining and publicizing how the spouse abuse counseling program would serve to help the community retain its cohesion, these services have been successful in reaching their target audience.

- **Support for the autonomy of the paraprofessional staff** has been critical in maintaining the link to the refugee community. Because the bicultural workers play a pivotal role in the care rendered to the refugees, support for their judgement and suggestions is integral. Additionally, the paraprofessional staff bring in many referrals from within the community. The perception of their important role is a powerful mechanism to encourage greater acceptance of mental health care among refugees.

- **Provision of off-site services** has also highlighted to refugees how CUHCC assists in the resettlement process by making the services less threatening and easier to access. Since the bilingual workers can bring their professional personas to the homes and gathering places of the refugees, they can actually initiate the treatment process in the hopes of encouraging entry into care at CUHCC as appropriate.

- **Diversified funding sources** have served the dual purpose of helping the program respond to the multi-dimensional needs of refugees while maintaining a relatively stable and durable funding base. Program administrators made concerted efforts to obtain funding in such areas us sexual assault areas counseling, spouse abuse counseling, chemical dependency prevention, and chemical dependency prevention, and child abuse counseling and prevention. These services augment mental health and social adjustment services.

C. SOUTHEAST ASIAN SUPPORT CENTER AT ST. JOSEPH HOSPITAL (Providence, Rhode Island)

The Southeast Asian Support Center, located at St. Joseph Hospital in Providence, Rhode Island, is a community-based outpatient mental health program providing culturally appropriate services to Cambodian, Vietnamese, and Hmong refugees. The Center operates in association with the hospital's Community Outreach Health Services, a unit established in 1986 to assure access to hospital services for ethnic and linguistic minorities in the area.

As with the program at the Lynn Center outside Boston, the Southeast Asian Support Center offers an example of a mental health program integrated with primary health care services, thus reducing the stigma associated with mental disorders. The Center's emphasis on home visits further avoids this stigmatization. Creative and highly effective advocacy efforts have also been key to its success.

1. Refugee Mental Health Services in Rhode Island

Although refugees have been arriving in Rhode Island since 1976, services designed to meet their mental health needs have been relatively slow to develop. This delay was in part due to basic communication difficulties, particularly an initial inability of refugees to articulate their needs. Cultural factors also played a role. Southeast Asian refugees typically expressed emotional problems through somatic rather than psychological complaints.

Evidence of serious mental health problems in the refugee communities, however, soon began to appear. The first response to this realization came in the form of a Federal initiative. In 1978, funds were provided by the Federal Office of Refugee Resettlement to support the establishment of a regional mental health program based in Boston but offering services to the Rhode Island refugee communities as well. This project provided consulting assistance and a modest level of casework services through the local refugee resettlement system and directly to individual refugees, Upon termination of this Federally funded program, the state Office of Refugee Resettlement kept minimal mental health services

functioning in the state by funding a single position for a bicultural mental health worker at the Providence Community Mental Health Center (currently known as the Providence Center for Counseling and Psychiatric Services). When the bicultural worker left in early 1983, however, funding was terminated, and Rhode Island was left essentially without mental health services for almost two years,

Awareness of the dimensions of the mental health problems among refugees continued to grow. Service providers, particularly the Visiting Nurses Association (which established a Refugee Health Coordination Unit in 1983), identified and documented an increasing number of serious mental health and adjustment problems in the refugee communities.

The Northern Rhode Island Community Mental Health Center responded first. Using municipal monies matched by state funds, the Center hired a Laotian bicultural worker and trained him to provided basic counseling services. In January of 1985, mental health services for refugees were re-established at the Providence Center with the creation of a half-time position for a Cambodian paraprofessional worker.

Even with the two programs in place, however, it was widely recognized that a comprehensive response to refugee mental health needs would require the investment of additional funds and the involvement of new service resources, some possibly from outside the conventional mental health service system.

2. The Southeast Asian Support Center

In January 1988, the Southeast Asian Support Center began offering mental health services to refugees. The Center is situated in St. Joseph Hospital, one of the main private, Catholic hospitals in Providence, conveniently located in the refugee neighborhood. The Center operates in association with the hospital's Community Outreach Health Services. Situated in the hospital, the Center is easily accessible to mentally troubled refugees seeking help for physical complaints. Refugee clients are able to receive needed services without having to acknowledge that they are participating in a mental health program.

The Center's approach to service delivery is distinctive in its emphasis on serving clients in their own homes, Home visits are the primary and preferred service-delivery mode. Further, the Support Center did not adopt orthodox mental health services; rather, it has taken a more holistic approach to responding to the needs of refugees. The program has been particularly successful in helping refugees experiencing simultaneous physical, mental, and adjustment problems.

The Support Center is the only refugee-serving program in Rhode Island with full-time involvement of an American mental health professional: a psychiatric nurse. This uniqueness encourages a particularly close relationship between the American professional and the Center's bicultural staff, consisting of one full-time Chinese Vietnamese social worker, two full-time paraprofessional Cambodians, and one part-time Hmong paraprofessional. This close collaboration and support between the staff members was particularly important during the program's start-up phase when the bicultural workers were learning the basic skills required in their work. Senior psychiatric backup to the program is provided by the hospital's Chief of Psychiatry.

Currently, the Center serves approximately 80 families. The program's coordinator believes that services are being provided at capacity, at least until the bilingual workers are able to operate with greater autonomy. The Center's current funding totals approximately $200,000, including $70,000 from the Department of Mental Health, Retardation, and Hospitals, and $40,000 from the Department of Family and Child Services. The remaining funds come from a variety of private foundations, corporations, and banks.

3. Origin and Development of the Center

In order to understand the advocacy effort leading to the establishment of the Southeast Asian Support Center at St. Joseph Hospital, one has to go back to the early 1980s and the involvement of the Visiting Nurses Association (VNA) in health care delivery to refugees. VNA was one of the first health care providers in Rhode Island to come in contact with Indochinese refugees. In these early days, they saw primarily Hmong refugees. As the

number of refugees increased and new ethnic groups settled in Providence, the nurses saw a growing need for specialized health services for refugees.

In the winter of 1982, the state office of Refugee Resettlement issued a request for proposals to establish a refugee health coordination unit. The nurses took advantage of this opportunity, submitted a proposal, and were awarded the grant; the coordination unit opened its doors in April of 1983. It was located in one of the elementary schools in the inner city. Knowing that the grant provided by ORR would last only three years, VNA applied to the Rhode Island Foundation for additional resources. The nurses were looking for' a more stable home for their program. They decided that St. Joseph Hospital should be the target of their advocacy effort.

The next step was to search for allies. VNA teamed up with the local Catholic voluntary agency which had maintained a good working relationship with the auxiliary bishop. The two groups requested a meeting with the president of St. Joseph Hospital to discuss improved access to hospital services for ethnic and linguistic minorities in the area. The auxiliary bishop, in whose jurisdiction St. Joseph is located, was also present at the meeting. The VNA nurses came to the meeting with a thorough documentation of the refugee health care needs, including input and direction stemming from consultation with leaders from the refugee communities. They presented the hospital administrators with a typewritten needs assessment based on their own efforts to serve refugees and extensive interviewing with key refugee leaders. They left the hospital with assurances that a community outreach Health Services unit would be established.

The hospital kept its promise, and the community outreach office was opened in 1986. The hospital hired one full-time Cambodian and one full-time Hmong interpreter, and a part-time Spanish interpreter. The two VNA nurses became the coordinators of the refugee health services program.

Over the several years of their involvement with refugees, the nurses recognized that their clients had many mental health and adjustment problems, which often presented themselves in somatized form. No culturally sensitive mental health center existed for the

referral of refugees, however. One of the nurses decided to attend graduate school and earn a degree in psychiatric nursing to further her own ability to deal with mental health problems of refugees. She also embarked on another lobbying effort to establish a mental health program for refugees.

She knew from experience that the advocacy process is long and the road to success full of obstacles. Previous efforts taught her the importance of allies. This time she found them in the members and the chairman of the Governor's Advisory Council on Refugee Resettlement. The chairman, a son of Holocaust survivors and a successful businessman with political influence in the state, was very sensitive to the mental health needs of Indochinese refugees. He used his influence with the governor who, in turn, raised the issue of mental health services for refugees with the commissioner of the Department of Mental Health, Retardation, and Hospitals; for the first time in FY 1988, the state set aside funds designated specifically for the provision of mental health services for refugees. These funds, in the amount of $50,000, were awarded through a competitive bid to St. Joseph Hospital to establish the Southeast Asian Support Center.

4. Key Elements

The Southeast Asian Support Center grew out of successful advocacy efforts which made effective use of influential allies close to the governor's office. It developed a viable multi-dimensional service approach, based on home visits rather than hospital care. A number of elements appear to have contributed to the success of the Southeast Asian Support Center, including:

- **Co-location with physical health services in** a hospital setting enhanced access to and effectiveness of mental health services. St. Joseph Hospital has long been recognized by refugees as a primary health care provider, thus, there is no reluctance to seek help for other problems and referrals are readily facilitated.
- **Home visits** as a primary service mode have allowed the staff to assess mental health needs in the context of the refugee's family and living situation and avoid the potential stigma of institution-based care.

- **A multi-dimensional or "holistic" approach** to addressing refugee mental health needs has been used by the Center, with particular emphasis on helping refugees with simultaneous physical, mental, and adjustment problems,

- **Coordination of advocacy efforts with other refugee service providers** has led to strong coalitions. Teaming up with the local voluntary agency provided the Visiting Nurses Association with an entree to the bishop, a main decision-maker regarding charity care activities in the state. Membership in the Governor's Advisory Council on Refugee Resettlement also facilitated a working relationship with its chairman, another well-connected person in the state. The VNA also coordinated its efforts effectively with the key leaders in the refugee community, particularly through local Mutual Assistance Associations.

CHAPTER THREE:
REFUGEE SERVICES IN ETHNIC-BASED ORGANIZATIONS

Refugees are often members of a larger, already established ethnic, racial or religious group with similar needs and experiences. In areas with large Asian populations (Chinese, Filipino, Korean, Japanese and Samoan), one of the most effective strategies for increasing mental health services to Southeast Asian refugees has been to develop a structure under the aegis of a Pan Asian agency. Similarly, mental health services for Soviet and Iranian Jews have developed in Jewish social services agencies, and programs for Cuban refugees have been implemented by organizations that serve other Hispanic populations.

There are several advantages to this approach:

- Cost savings and efficiencies occur by developing added service capacity for refugees in an existing agency or network of organizations. Where these agencies have the language capacity to serve refugees, still further cost-benefits accrue.
- Many ethnic-based agencies have already developed expertise in dealing with cross-cultural differences and the need to meld Western and traditional practices, They do not need to be convinced of the benefits of hiring bicultural workers, for example.
- There is greater political clout in multi-ethnic or religious groups than can be found within one group. By joining with others, refugee advocates are able to vie more effectively for limited funds for mental health services.
- These agencies having preceded the refugee influx may be more likely than refugee-specific agencies to remain in operation over the long-term. By convincing them to add refugee-service capacity to the programs, refugee advocates will ensure that services are available after refugees cease to be eligible for refugee-funded programs.

This chapter offers detailed descriptions of three agencies which have followed this approach to mental health service delivery:

- Asian/Pacific Center for Human Development (Denver, Colorado);
- Union of Pan Asian Communities (San Diego, California); and

- Refugee Assistance Division for the Jewish Board of Family and Children's Services (New York).

A. THE COUNSELING AND TREATMENT PROGRAM AT THE ASIAN/PACIFIC CENTER FOR HUMAN DEVELOPMENT (Denver, Colorado)

The Asian/Pacific Center for Human Development (A/PCHD) is a Colorado state certified specialty mental health clinic providing various kinds of assistance to Asians, ranging from clinical, outpatient, and day treatment mental health services; vocational rehabilitation programs; and social adjustment programs for women, youth, and the elderly.

A/PCHD is a good example of an organization that moved from reliance on Federal refugee funds for Southeast Asian services to a more diversified funding base. It is now a stable, large organization that relies on a multi-faceted service approach.

1. Mental Health Services in Colorado

The mental health system in Colorado is a fairly centralized one; most of the authority resides at the state level where financial and programmatic decisions are made. The state mental health budget is appropriated on an annual basis. The state takes maximum advantage of Medicaid reimbursement, which in Colorado is made available to both mental health professionals and paraprofessionals.

Colorado is moving increasingly towards an emphasis on the severely mentally ill -- persons who are chronically mentally ill or deemed to be in danger to themselves or others. This focus comes from both the legislature and the Division of Mental Health. As a result, agencies like the Asian/Pacific Center have had to rely on diversified funding to serve refugees with less severe mental health problems as well as those that meet the state definitions.

2. The Asian/Pacific Center for Human Development

The Asian/Pacific Center for Human Development was established in 1976 when a group of mental health professionals of Asian descent formed a support group called the Asian Human Service Association. This group included mental health professionals working in local mental health centers, area universities, and private practices. The two unifying factors of the group were their common Asian origin and the fact that in their respective professional activities they had to deal with Asian patients. At first, they encountered Asian patients sporadically, but with the fall of Saigon and subsequent events in Cambodia and Laos, they saw increasing numbers of Southeast Asian clients.

The Asian Pacific Development Center (APDC) incorporated in 1980. It remains the parent company of two organizations: the Asian/Pacific Center for Human Development (A/PCHD) and the Asian American Foundation of Colorado (AAFC). The APDC remains the parent company, rendering management services and developing new programs. A/PCHD provides mental health, vocational rehabilitation, and community education programs to Colorado Asian and Pacific Islander residents. It is a certified specialty mental health clinic contracting with the Division of Mental Health, and a United Way agency. The AAFC has a two-fold mission: to raise funds for APDC and A/PCHD, and to help Asian communities maintain their cultural heritage.

Each organization has its own Board of Directors. They are members of the original board of APDC which decided to separate in order to better utilize their skills and strengths. The members with expertise in the mental health field served on the Asian/Pacific Center for Human Development Board to oversee and help the staff with programmatic issues, while those experienced in fund-raising and lobbying decided to serve the Asian American Foundation to continue fund-raising and advocacy efforts. New Board members skilled in management, legal, and financial fields were recruited to serve on the holding company of the APDC.

A/PCHD's current funding exceeds $750,000. Approximately $300,000 comes from Medicaid (with a 50/50 split between Federal and state dollars). An additional $44,000 is

provided by the Colorado Division of Mental Health to serve medically indigent clients. The local United Way provides $100,000 in core support and approximately $300,000 in grants for special projects, e.g., outreach to the elderly, domestic violence, and gang prevention. The Center also receives smaller amounts from Victims' Assistance, law enforcement, spouse abuse, and other programs. The Federal Action Program provides support for different types of prevention efforts, such as substance abuse and youth-focused programs.

Currently A/PCHD has 37 full-time, part-time, and contract employees. Twelve of these are of Southeast Asian origin, including Vietnamese, Hmong, Laotian, and Cambodian. Professionals account for 50 percent of the Center's staff, including certified clinical psychologists, MSWs, and MAs. The staff represents 19 different ethnic groups and languages. The language capability of the staff is supplemented by the Interpreters' Bank, the newest venture of the Center. The Bank provides interpreters not only in Indochinese language, but also in Farsi, Amharic, Tigrigna, Polish, and Spanish.

Staff development is ensured through ongoing training in-house. Every Monday all staff, particularly the bicultural paraprofessionals, participate in two two-hour classes; one conducted by a volunteer who is a clinical psychologist affiliated with local universities and another by the clinical director of the Center.

3. Services Available to Southeast Asians

Diversified funding sources enable the Center to provide a wide array of assistance in 19 Asian languages to their Asian clients, including clinical, outpatient, and day treatment mental health services; vocational rehabilitation programs; and support groups for women, youth, and the elderly. This assortment of services offered at the Center is congruent with the Asian holistic view of illness. Traditional Asian societies believe that disease, including mental illness, is a product of the loss of natural equilibrium of body, mind, and nature. Furthermore, it represents dysfunction not only within the patient's body., but also in his relationship with society and, perhaps, dysfunction within the society. Thus, return to health means restoration of the harmony of all these elements.

The Asian/Pacific Center for Human Development tries to address the special needs of its clients through three distinct service divisions:

- Division of Clinical Services:
- Division of Vocational Services; and
- Division of Training.

The last two Divisions are the real “money-making” departments, for without them and with constrained funding for mental health services and lack of funding for preventive and adjustment types of services, the Center would not be able to survive. With good budget management and creativity, A/PCHD is able to provide the support and preventive services which help to ensure that refugees do not become severely or chronically mentally ill.

a. Division of Clinical Services

Division of Clinical Services is an outpatient mental health clinic funded by the state of Colorado Division of Mental Health. The Division serves the Asian and Pacific Islander population of Colorado. Staff includes bicultural clinicians trained in mental health services. The clinic serves limited English speaking or monolingual clients of Korean, Japanese, Chinese, Filipino, Vietnamese, Cambodian, Laotian, and Hmong origin. Volunteer clinicians are also available to serve those who speak other Asian languages. In addition, the clinic trains interns for local universities in the fields of psychology (Ph.D., Psych. D., and M.A. programs), counseling (Ph.D. and M.A. programs) and social work (M.S.W. and B.A.).

The Division provides a broad range of services:

- **Outpatient mental health services** for individuals, families and groups include 24-hour emergency care; psychological and psychiatric evaluations; partial day treatment; and consultation and education services for schools, hospitals, and social service agencies.
- **The partial day treatment program serves** clients who are chronically mentally ill (CMI). Most have long-term mental illness, such as schizophrenia or bi-polar disorders. These clients are generally well maintained on medications and

function relatively well. The day program also serves refugees who have suffered traumatic experiences during the flight from their home countries, and have difficulty holding jobs, maintaining relationships with others, or carrying out daily activities, The partial day program includes English as a Second Language classes, group therapy with a clinician speaking their native language, horticultural and art therapy, and opportunities to socialize with their **fellow compatriots.**

- **Programs for the elderly, youth and families.** The Denver Regional Council of Government (DRCOG) has provided funding for outreach and socialization programs for the home-bound Asian elderly. Presently, Japanese, Chinese, Korean, Lao, and Vietnamese senior groups participate in weekly activity programs, conducted in their native languages.

  The Center's clinicians are also trained to assist refugees and immigrants experiencing intergenerational conflicts. 'These conflicts usually arise when children adopt American values very quickly, while parents attempt to retain traditional Asian values Children and adolescents often experience difficulties resolving their sense of 'Asianness,' struggling to integrate both the Asian and American cultures," explained Kham Ko Ly. The Center cooperates with the public school system and its clinicians provide consultations to school districts with a significant number of Asian students.

  The Denver Department of Social Services funds the Center's domestic abuse assistance program. Under this grant, the Center works with shelters to provide treatment and consultations **in** cases where violence has occurred within the family. The United Way also funds a Youth at Risk program, targeting Asian youth exhibiting behavior problems, alcohol and drug abuse, and signs of dropping out of school.

  Finally, an ORR Targeted Assistance Grant finances support services for refugees who are having difficulty finding or holding jobs. These funds enable the Center to help refugees with their adjustment to a new culture, as well as understanding the American world of work and the employment system.

b. Division of Vocational Services

The Division of Vocational Services began in 1985 with funding from the Colorado Division of Rehabilitation. Its objective is to provide vocational training to the Center's mentally ill clients and low-income, hard-to-place Asians. According to the Center's newsletter,

The Supported Employment Project for the Chronically Mentally Ill, Limited English Speaking Asian exists because traditional vocational training programs have not been successful for this client group. The service providers' limited understanding of Asian cultures and languages are the main reason for this problem. By providing a culturally sensitive environment and a supportive employment plan, A/PCHD plans to train, encourage, and motivate the client to develop good work skills in preparation for the competitive work world.

The vocational program is closely tied to the clinical and instructional services. This connection allows the clients to receive counseling and take advantage of ESL (English as a Second Language) classes, horticulture, and art therapy-while furthering themselves vocationally. Among the graduates of the program are several trainees who have advanced to the intermediate level in food-preparation. Two clients have continued their training with additional course work in culinary arts and are currently seeking employment in the marketplace. In the spring of 1988, the Asian Cafe was opened as an adjunct to the Asia Food Catering operation which has been in existence since 1986. It serves both as an on-site training ground and as an income-generating project. In 1989, the Center received funding from the Denver Employment and Training Administration (DETA) to provide supported employment programs to low-income, hard-to-place Asians.

c. Division of Training

The Division of Training was established in June 1986 in order to prevent mental health related problems among Asian residents in Colorado through the provision of education and skill training; and to provide workshops to corporations, law enforcement agencies, schools, and other human service agencies on Asian cultural values, attitudes, and behavior which enhances their capacity to work with Asian clients.

This Division is funded in part by the Mile High United Way. With the assistance of the VALE fund (Victim's Assistance and Law Enforcement), the Division of Training developed curriculum and held workshops on crime prevention and victimization. The curriculum was translated into Vietnamese, Laotian, Cambodian, Chinese, and Korean. Recognizing a strong need for Asian victim advocacy, A/PCHD trains Asian volunteers to

serve as advocates. They translate for victims, educate them regarding their rights, provide information and referrals, and provide emotional support during court procedures. In order to prevent rapid turnover of trained advocates, funds have been set aside to compensate volunteers for mileage and lost wages.

4. Origin **and Development of the Services**

Initial funding for refugee services was provided by the Federal Office of Refugee Resettlement (ORR). The $50,000 provided by ORR enabled the Center to hire three full-time and two part-time staff members, including a full-time Vietnamese and Hmong paraprofessional, and a part-time Vietnamese counselor to work with a women's support group.

In the course of the first eight months of its formal existence, the Center served approximately 100 clients. In July of 1981, ORR funds to the center were terminated. In conformance with the Refugee Act of 1980, all ORR funding began to be funnelled to the states and was no longer available for direct support of service providers such as APDC. Only two staff members remained working on a volunteer basis at the Center.

Faced with the lack of funding from ORR; the Board of Directors of the Center began to lobby the Colorado Division of Mental Health for funds to continue their services for refugees and other Asian minorities. They decided to expand their services to all Asians in the Denver metropolitan area, and thus gained the support of highly influential Asian Americans in their community.

The current Executive Director, then President of the Center's Board of Directors and a state employee of the Division for Developmental Disabilities, used both her knowledge of the state mental health system and political clout to influence the Division of Mental Health. At that time, her aim was to have the Asian/Pacific Center for Human Development be recognized as a state specialty mental health clinic and receive appropriations from the state. She knew that this status would enable the Center to receive Medicaid dollars on a clinic option level. Her efforts were successful. In January 1982, the Asian/Pacific Development

Center became a part of the state contracted community mental health system and received the status of a specialty clinic.' APDC signed memoranda of understanding with mainstream mental health centers stating that all monolingual Asian patients in need of outpatient programs would be served at the Center.[2] Approximately 65 percent of the Center's patients are refugees.

This new status, however, did not bring the expected funds because the state's fiscal budget had already been determined. The Center was told that they had to wait until the next fiscal year budget for appropriation of funds, The advocates were persistent, however. They decided to lobby the legislature, targeting the Joint Budget Committee of the state legislature with their advocacy efforts. Aware of the particular interest in mental health issues of the local senator (whose son was mentally retarded), they made him their ally. He made a motion on the Senate floor and, as a result, a $68,500 budget supplement was appropriated to the Center for FY 82-83. These monies were to be used as a Medicaid match or to serve medically indigent patients. Lobbying efforts continued in the following years. They resulted in a two-fold increase in appropriated funds from the Division of Mental Health.

5. Key Elements

The Asian/Pacific Center for Human Development is a large organization that has the capacity to provide mental healthservices to refugees in tandem with an array of other services, Having been reliant initially on Federal refugee funds, A/PCHD now has a diversified funding base. A number of factors have contributed to the achievements of the A/PCHD:

- Maximization of Medicaid and other third-party payments, by becoming a state certified and contracted clinic. In Colorado, this allows for reimbursement of services provided both by mental health professionals and paraprofessionals on a "clinic option level" (see Part Ill for further discussion of this issue).

---

1 APDC is a private, nonprofit organization and is one of 20 state contracted community mental health centers and clinics. It is not a state agency.

2 Those who need inpatient care are served by comprehensive community mental health centers.

- **A willingness to become a specialty clinic which** made Medicaid funds available to the Center on a clinic option level and permitted expansion of offered services.

- **Diversified funding sources** which enabled the Center to provide many kinds of assistance to its Asian clients, ranging from clinical, outpatient, and day treatment mental health services, to vocational rehabilitation programs, and support groups for women, youth, and the elderly.

- **A multi-dimensional approach** to **service delivery which improved both access and** effectiveness of mental health services. The center provides a broad array of services and supports beyond traditional mental health therapy. The goal is to ensure that physical and environmental problems (e.g. lack of employment) are addressed as well as mental health problems. This approach is congruent with the traditional Asian view of health and illness and is particularly valued by the elderly.

- **The Pan Asian approach** that ensured alliance with more politically powerful Asian groups, and helped in efforts to obtain public and private funding.

- **Experienced and committed Board of Directors.** In recruiting Board members, the Center not only ensures that all Asian groups are represented, but also seeks candidates with particular skills (legal, fund-raising, entrepreneurial, etc.). The Board of Directors has been invaluable in the Center's advocacy and lobbying efforts.

B. UNION OF PAN **ASIAN COMMUNITIES (UPAC) (San Diego, California)**

The San Diego Union of Pan Asian Communities started in 1974 with outreach mental health services to Japanese, Chinese, and Samoan populations. When Federal funds became available to provide basic refugee resettlement services in 1975, UPAC applied. Since then, UPAC has expanded its functions to include a variety of social services, such as nutrition support for the elderly, and has consolidated its position as the mental health provider for Asian and Southeast Asian populations throughout the county of San Diego. UPAC now operates a full-scale outpatient mental health clinic.

UPAC's diverse array of services makes it of particular interest for advocates on behalf of mental health services for refugees. Its strong commitment to bicultural staff as well as its good relationship with the mainstream mental health system make it a model program. So too are its diverse funding sources.

1. Mental Health Services in California

California's mental health system is highly decentralized. Most of the power and authority is at the county level. Counties have a great deal of discretion in how they define both their priority population and their funding priorities. California commits a large portion of its funds to community-based services, ranking first in the country in this regard. Atypically, the state's budget for community-based services is higher than its budget for state mental health hospitals.

2. UPAC and Mental Health Services

UPAC began in 1974 by providing outreach services to several Asian groups. In the mid-1980s, it became an outpatient clinic as well as an outreach provider. This expansion necessitated a much more elaborate and professional organization of the agency. UPAC provides clinical and outreach mental health services and a wide range of other social services using ongoing state and county mental health funds and a variety of grant monies.

At this time, the county mental health funding seems secure: "We've never been on the chopping block," said the Executive Director of UPAC in an interview. Elected and appointed officials are well-educated and sympathetic to the needs of refugees and UPAC has developed considerable political influence. The agency's current goal is to increase private fundraising in order to be able to raise staff salaries and provide programs that do not have other funding sources.

Among the multiple programs operated by UPAC, six in particular serve Southeast Asians as well as other Asian populations. While mental health is not the central focus of all six programs, UPAC views each of the programs as potentially important in helping to meet refugee mental health needs. The six programs are as follows:

- **Counseling and Treatment Center.** The counseling and treatment center is an outpatient mental health clinic. The Center provides both clinical and community mental health services, such as crisis intervention, outreach, mental health promotion, community education, and consultations for Pan Asians in

San Diego County. Bicultural paraprofessionals serve persons unable or unwilling to come to the clinic. Staff consists of four licensed clinical social workers (including a half-time program director); 1,020 hours of contracted psychologist, psychiatrist, and nurse time; four bicultural paraprofessionals; and two administrative staff. The four paraprofessionals are Laotian, Vietnamese, Cambodian and Hmong. Over two-thirds of the clients are Southeast Asians. The remaining one-third include other Asian populations. The largest diagnostic group presented at the Center is major depressive disorder, followed by schizophrenia and other psychotic disorders.

For 1988/1990, the Center budget totalled $309,775. The clinic is set up to bill Medicaid for services (under an unusual "pilot program" available only in California, see description in Part III) which requires demonstrating "medical necessity" and standard psychiatric diagnoses. Roughly one-quarter of the clinic funding is Medicaid dollars.

- **The East Wind Socialization Center** is an innovative demonstration project funded by a State Block Grant to the San Diego County Department of Mental Health. The project provides culturally appropriate mental health rehabilitation services targeted for Southeast Asians who are chronically mentally ill, but have difficulty using mainstream mental health services due to language and cultural differences. The objectives of the program are to improve independent living skills, increase normalization, and decrease isolation and frequency of rehospitalization. In its efforts to increase self-sufficiency, independence, and productivity, East Wind provides a variety of programs to meet the unique needs of individual clients: English as a Second Language courses; pre-vocational training; structured socialization; health education; individual counseling; community education; and assessment, evaluation, and referral. The Center is staffed by one licensed clinical social worker who also serves as program director, two bicultural paraprofessionals, and a half-time administrative support person. The annual budget is $105,000.

- **Southeast Asian Developmental Disabilities Prevention Program** is funded by the US. Department of Health and Human Services, Office of Maternal and Child Health, through a subcontract with the San Diego/Imperial County Developmental Services, Inc. The purpose of the program is to provide outreach, early identification, and intervention services to Southeast Asian infants who are at risk for handicapping conditions and developmental disabilities.

- **Pan Asian Children's Services** are funded by the California Office of Child Abuse Prevention to provide prevention and intervention services to reduce the incidence of child abuse and neglect in the Pan Asian community. Services such as parenting education, counseling, and support services are provided to prevent further child abuse, avert family break-up and re-unite families.

- **Pan Asian Language Assistance Center** is funded by the United Way of San Diego. The purpose of the project is to assist new immigrants and refugees in

resolving emergency situations, to become more self-sufficient, and to facilitate cultural adjustment. The Center provides bilingual case management services for Japanese, Korean, Samoan, Guamanian, and Vietnamese clients.

- **Services for the** Elderly include in-home support services for Southeast Asian elderly, a nutritional program providing meals to the elderly, and a volunteer program designed to enhance elderly access to various community service providers through cultural awareness training and other activities.

3. Origin **and Development of the Services**

Although UPAC already provided some mental health services to Asians and resettlement services to refugees, it took two years of lobbying at the county level to obtain specific funding for outreach mental health services to Southeast Asians. The lobbying consisted of a wide variety of efforts to educate the Board of Supervisors and other officials about the needs of the population and a focused attempt to alter mental health funding priorities.

Most effective in these efforts was a university professor with a special interest in refugees who took a position on the county Mental Health Advisory Board (MHAB). By law, each of California's 58 county mental health programs must have a 15-member Mental Health Advisory Board. The Board's duties are to advise both the Board of Supervisors -- which appoints the MHAB members -- and the county Director of Mental Health. Although a statutory requirement mandates that ethnic minorities be represented on the MHAB proportionately to the minority population in the county, few Southeast Asians have been approached to sit on these boards. The NIMH-sponsored needs assessment (See Part I) of 10 California counties with the highest number of Southeast Asian refugees found only one board with a Southeast Asian member.

Although MHABs do not technically have much power, they can be very influential in funding decisions. In particular, they can present the needs of specific groups to the Board of Supervisors even **if the local mental health department accords** those needs low priority. The MHAB can also be useful in moving a local mental health department toward planning for culturally appropriate services even when funding is not immediately available.

The professor was successful in wielding such influence. He advised other refugee advocates to be single-minded and assertive while not appearing to be insensitive to the needs of other special populations. The effectiveness of this focussed advocacy effort was facilitated by the broad base of support already enjoyed by UPAC as a pan-Asian organization. Asians are a large constituency in San Diego, and UPAC itself is generally respected and supported by county supervisors as well as county service agencies.

In addition to the advocacy effort at the county level, a variety of other grant-based funding sources have been used over the years to develop and maintain a refugee service capacity, including a grant from NIMH for training of paraprofessionals. Some of these grant-funded projects (e.g., a special child abuse project) have served to ease the burden of finding mental health funding for refugee services.

4. Key Elements

UPAC has succeeded in becoming a large, stable organization that meets a wide range of refugee needs, both for mental health and other social services. The following factors contributed to UPAC's success:

- Alliance **of refugee populations with more politically powerful groups of Asians** increased the capacity of the center to argue successfully for funding, particularly from public sources. UPAC has established itself as an enduring and capable provider, and is respected and well-known by policy-makers and county service agencies. Thus the request for services on behalf of Southeast Asians found a receptive audience.

- **Intensive educational efforts with elected and appointed officials.** UPAC lobbied effectively with the County Board of Supervisors through the Mental Health Advisory Board. Particularly helpful was the strategic use of information on refugee needs as well as the persistence and dedication of a particular supporter on the Board.

- **Linkages with other services providers.** UPAC has had ongoing relations with the county social service agencies for many years, which has proved helpful in gaining support for new service initiatives. Programs such as East Wind also made particular efforts early in their existence to establish linkages with other mental health providers, ethnic community leaders, hospitals and discharge planners, etc.

- **Efforts to make the services culturally and psychologically appealing.** Staff of the East Wind Socialization center, for example, engaged in considerable "trial and error" as they gradually learned how to make clients comfortable in a program designed to help address serious mental health needs. Particularly important were: (1) culturally appropriate group activities in which clients could relax with others from their cultures, eat familiar foods, or listen to familiar music; (2) identity of the program as "educational" (e.g. referring to various activities as "classes") rather than therapeutic or a place for "crazy people"; and (3) an emphasis on the building of "survival skills" as the major goal of the program rather than "independence". The latter concept, originally a formal and articulated goal for clients, was often resisted because of a cultural believe in interdependence and the central importance of supports within the family unit.

- **Outreach efforts,** particularly home visits, which proved to be important in overcoming a cultural tendency for clients to avoid participation in the programs unless specifically invited and encouraged to attend.

- **A multi-dimensional service approach, coupled with diversified funding.** For many years UPAC has been involved in a wide range of services for Asian populations. A multi-faceted approach to the mental health needs of refugees followed naturally from this approach and has proved to be a strength of the program. Clients receive not only therapeutic services from the counseling and treatment center, but can also participate in the socialization and skill-building activities of the East Wind Center as well as other UPAC programs. The breadth of programming at UPAC has also been key in stability of program funding.

- **Certification as a mental health clinic.** UPAC was willing to take the difficult step of becoming a clinic so that Medicaid funds (with a 50 percent Federal match) could be used, thereby greatly expanding available services and funding.

- **A strong commitment to bicultural paraprofessional staff** who are treated as equals at UPAC, and who are generally viewed as indispensable to the success of the various programs .

C. REFUGEE ASSISTANCE DIVISION: JEWISH BOARD OF FAMILY AND CHILDREN'S SERVICES (New York, New York)

Jewish Board of Family and Children's Services (JBFCS) has provided mental health services to refugees since the late 1970s when the agency began a program for Soviet adolescents. Two years ago, it established a Refugee Assistance Division (RAD/JBFCS) which is directed by a Soviet-born clinical psychologist and staffed with consulting

psychiatrists, clinical social workers and paraprofessionals, Both Soviet and Iranian Jews are seen in programs located at the offices of the New York Association of New Americans (NYANA) in Manhattan and in three clinics/social service centers located in other parts of the city with large concentrations of refugees. In September, JBFCS and NYANA will cooperate on a training program designed to increase the number of licensed clinical social workers available to the program.

The program at JBFCS illustrates an effective working relationship between a resettlement agency and an ethnically based, mainstream mental health agency. The resources of both organizations are utilized in order to ensure that the full service needs of refugees with mental health problems are addressed.

1. Mental Health Services in New York

New York's mental health system is very complex. It has the largest mental health budget in the country, some $1.6 billion per year of which 75 percent comes frbm state revenues. The remainder comes from the Federal government and third-party reimbursements for services. About $1.3 billion goes toward state mental health hospitals, with only $200 million allocated to community-based programs. Mental health services are limited for all populations. Only persons who are chronically mentally ill or deemed to be a danger to themselves or others can be treated in state mental health facilities.

2. The Need: Resurgence of Soviet Admissions

There have been two major waves of Soviet Jewish migration into the United States. The first began in the 1970s and continued for about 10 years. By the end of that period, 52,200 Soviet refugees were resettled in New York City. Beginning in 1981, emigration from the Soviet Union decreased and remained as a trickle until 1988. Then, with the emergence of glasnost and perestroika, the doors opened once more and new Soviet arrivals again entered the United States. In 1989 alone, more than 36,000 entered, with a large proportion settling in the New York area.

3. JBFCS and NYANA

The mental health services for Soviet and Iranian refugees involve two of the major providers of social services in New York. JBFCS is the largest private mental health program in the country. It runs a total of 100 programs in 70 locations throughout New York City, Westchester County and Nassau County. More than 45,000 patients are seen each year. Its programs include a network of outpatient mental health services, residential **schools, treatment facilities** for troubled adolescents, and programs for the developmentally disabled and chronically mentally ill. JBFCS also provides a comprehensive range of social services.

NYANA is the largest resettlement agency in the United States. It resettles Jews from various countries as well as other refugees, including Southeast Asians, NYANA receives funding from a variety of refugee sources, including State Department reception and placement grants, ORR matching grants, and social service contracts with the State of New York. It provides a comprehensive range of social services, language training, and employment services to refugees in New York. NYANA resettled 18,500 refugees in 1989 and provided services to more than 20,000 people.

4. Origin and Development of the Services

JBFCS began its refugee programming in the late 1970s when the first wave of Soviet emigres entered the United States. The first programs were an outreach service for Soviet adolescents who were showing signs of adjustment difficulties and an outpatient treatment program for other age groups. When the number of Soviet admissions began to decline through the 1980s, JBFCS continued the adolescent program but did not expand its other services except for limited programming for Iranian Jews who were unable to return to Iran after the revolution there. Funding for the adolescent program came from private grants and grants from the state's youth division. Additional services were provided through the matching grant program administered by the Jewish Federation.

Two years ago, recognizing that the numbers of emigres were beginning to climb and that the new arrivals would likely exhibit some of the adjustment problems found among

all refugee groups, JBFCS and NYANA decided to develop resources for providing a broader array of mental health services to the new refugees.

The program that was designed is largely the handiwork of its director, a Soviet emigre who received a doctorate in clinical psychology at New York University. Having completed a dissertation identifying the mental health needs of Soviet refugees, the director was well versed in this field. JBFCS provided support for the dissertation research. The director had begun working with JBFCS ten years previously as a case aid and was therefore very familiar with its operation in addition to the population with whom he was working.

The research indicated two major needs: 1) for initial services to help in immediate adjustment; and 2) for longer-term services. The model that emerged was designed to address both needs. There would be a refugee-specific program with biculturai staff that could deal with the special problems resulting from the refugee experience; and there would be concurrent efforts to increase the capacity of JBFCS's mainstream programs to deal with the longer-term problems, The program director noted three major areas in need of further development:

- **Services for the Chronidally Mentally Ill --** The major gap in RDA/JBFCS's service capacity relates to services for the severely and chronically mentally ill. There is need for hospital services for the acutely ill and a day treatment program for those with long-term, severe problems. Integration of refugees into ongoing day treatment programs is difficult because of the language barriers of the patients. And, to date, enough refugees have been identified who require such services to warrant a separate program.

- **Linkages with Physical Health Services --** RAD/JBFCS is currently working on developing better linkages with physical health services. The director recognizes that many symptoms of mental illness among refugees are somatized and that physical health facilities are a more acceptable place to seek help than are mental health clinics. Many of the health services available to Soviet refugees are provided by private practitioners so it will be necessary to establish linkages with a wide range of providers, making this option difficult to accomplish.

- **Medicaid Reimbursement --** RAD/JBFCS has not sought Medicaid reimbursement of services provided at NYANA. The NYANA office does not now have satellite clinic status, complicating the reimbursement process. The staff are looking into this situation.

5. Refugee Assistance Division - JBFCS

The program for Soviet and Iranian Jews may be described as a wheel with a hub and several spokes. The hub, run by RAD/JBFCS, is housed at NYANA to facilitate initial contact with the clients. It includes counseling, referral and consultation. The spokes, located at satellite facilities, include community-based programs, services for adolescents, volunteer services, hospital services, troubleshooting and training of mental health staff. The' division provided 1,000 individual consultations during the past year, with each patient receiving an average of three sessions. The total program was funded at the level of approximately $750,000.

There are two aspects to the program located at NYANA. First, the staff of RAD/JBFCS provides counseling and referral services. Second, the RAD/JBFCS program provides consultation to the NYANA staff to help them identify and address, where possible, adjustment problems seen in their clients.

Clients are generally referred to the RAD/JBFCS staff by the caseworkers at NYANA. Where the client requires a variety of services, in addition to mental health counseling or referral, the RAD/JBFCS and NYANA staff members confer on the development of an overall plan. If the client requires referral to an outside mental health agency, that occurs as well. As much occurs within NYANA as possible, though, because it is often easier for the refugees to accept treatment through a social service setting rather than a mental health clinic. Moreover, many of the clients require social services in addition to mental health services. The location of RAD/JBFCS staff in a social service/resettlement agency facilitates the process of providing the full range of services.

RAD/JBFCS staff participate in training programs to sensitize NYANA staff to the mental health needs of their clients. They work not only with the resettlement caseworkers but also with the vocational department. They also give presentations and hold group discussions with the refugees enrolled in the NYANA Jobs Skills Program regarding the psychological aspects of seeking and maintaining employment in a new country.

In addition to the "hub" service, RAD/JBFCS staff provide services in clinics and social service offices in three locations in Brooklyn. The role of the RAD/JBFCS staff is again two-fold: to identify and provide services to clients; and to train the mainstream social service and mental health providers to better serve the refugees who request assistance. RAD/JBFCS staff often provide case management services in order to ensure that the clients receive the full array of assistance that they may need. The intent of these community-based programs is to develop a longer-term capacity within the overall JBFCS structure to respond to the needs of Soviet and Iranian refugees.

A third program focuses on adolescents. Services include: a limited level of individual counseling; on-site consultation at schools and community centers; and acculturation and recreational programs. The aim is to identify adolescents who are at risk of mental health problems and to provide preventive services. As with the other programs, the adolescent services are provided in a community service setting in order to make sure that the adolescents are comfortable in seeking help.

RAD/JBFCS maintains close links with the Volunteer Services Department at JBFCS. For refugees whose problems stem from loneliness, the RAD/JBFCS staff can arrange for "friendly visitors" to come to their homes, This approach is particularly helpful with refugees who do not have family members in the United States. RAD/JBFCS staff also provide training modules for volunteers to help them deal with the cross-cultural issues arising from working with refugees.

RAD/JBFCS staff also provide a troubleshooting function. When refugees seek services from or are identified by mainstream agencies within and outside the Jewish social service sector, the RAD/JBFCS staff will provide consultation and assistance in establishing an appropriate plan. This function brings the staff into contact with school systems, health services, police and others.

Finally, RAD/JBFCS has established linkages with Beth Israel Hospital for inpatient care. The hospital has agreed to provide priority intervention for patients referred by the NYANA program. In exchange, the RAD/JBFCS staff provide translation, Some outpatient

care is provided at Coney Island Hospital which has Russian-speaking psychiatrists in the outpatient department.

6. Professional Development

A major problem faced by RAD/JBFCS has been recruitment of licensed, culturally-sensitive staff for the program. To address this issue, RAD/JBFCS and NYANA are embarking on a project modelled after an earlier NYANA effort. Last year, NYANA put into place a subsidized training program for social workers. Bilingual staff at NYANA have been encouraged to enroll in the **school of social** work at Yeshiva University. They receive a scholarship and full salary. In exchange, they work at NYANA for their school placement (amounting to about 40 percent time) and agree to maintain full-time employment at NYANA for two years following graduation.

In September, RAD/JBFCS and NYANA began the Services, Employment and Training (SET) program, for the training of licensed clinical social workers for the mental health program. Yeshiva University is providing six partial scholarships and RAD/JBFCS and NYANA will pay full salary while their bilingual staff obtain a Masters in Social Work. Funding is being provided through the Jewish Federation's Passage to Freedom fundraising effort.

The advantages of this approach are several. First, the agencies will have a complement of well-trained staff. Second, the bilingual staff, many of whom have degrees from Soviet universities, will be able to move from paraprofessional to professional positions. Third, services provided by these staff will qualify for some form of third-party reimbursement because they will be licensed. Fourth, these staff will be able to move into JBFCS mainstream services if the need for them at the NYANA-based program diminishes because of fewer new arrivals relative to the number of already resettled persons.

7. Key Elements

The Refugee Assistance Division at the Jewish Board of Family and Children's Services draws on the strengths of a resettlement agency and a large, well-funded Jewish

social service agency to offer a comprehensive set of mental health services. This co-location also has drawbacks. Financial constraints require that the program continue to explore new funding sources, such as Medicaid reimbursement, but its location in a resettlement agency makes it difficult to obtain certification as a clinic that is able to receive Medicaid funds,

A number of factors appear to have contributed to the successful implementation to date of the RAD/JBFCS programs:

- **A multi-dimensional approach to service delivery. Mental** health services are provided in the context of the overall resettlement needs of the clients. The program recognizes that some psychological adjustment problems are related to the situation in which refugees find themselves (e.g., unemployed, homeless) while some economic adjustment problems are related to mental health problems. The close working cooperation among staff involved with all of these services allows for the development of a plan that addresses all of the client's needs. It also ensures that few individuals who need services will fall through the cracks since both staffs are sensitized to the importance of each other's contributions.

- **Location in social service agencies** also reduces the stigma attached to the receipt of mental health services. This is particularly important in the adolescent program, but applies to adults as well. In the Soviet Union, psychiatry was often misused for political repression and is therefore suspect among many refugees. They do not feel as uncomfortable seeking or obtaining social services.

- **A training component is part of the overall program. Even before** the **advent of** the SET program, RAD/JBFCS and NYANA were committed to in-service training for both agencies' staff. With the new training program, there should be substantially increased staff capability as well as an improved capacity to capitalize on third-party reimbursements. The SET program, while not totally replicable elsewhere, provides an important model for other social service agencies. JBFCS and NYANA used their connections to a Jewish university to negotiate scholarships for their bilingual workers. Other ethnic or religious - based agencies (for example, Catholic Social Services) have similar connections to university schools of social work.

- **Continuity in addressing initial resettlement needs and longer-term needs.** The same RAD/JBFCS staff work out of the NYANA program and the community programs, thereby ensuring that clients who need longer-term services will be seen by the same staff as they move from the resettlement agency to their community-based agencies.

- **A team that encompasses a variety of skills and backgrounds.** The RAD/JBFCS team includes psychiatrists, psychologists, clinical social workers and paraprofessionals. The Director of the program, an emigre and U.S.-trained psychologist, recognizes the importance of both cultural sensitivity and professional skills.

CHAPTER FOUR:
SPECIALIZED MENTAL HEALTH CLINICS FOR REFUGEES

Experience shows that in some states with a long-standing history of refugee resettlement and a resulting large refugee population, such as California or Massachusetts, the critical mass has allowed the establishment of specialized services for refugees. The advantage of these specialized programs is their ability to design and tailor services to the specific needs of these particular populations.

This chapter will provide a detailed description of three specialized mental health programs for refugees:

- Metropolitan Indochinese Children and Adolescent Services in Boston, Massachusetts,;
- Southeast Asian Women's Alliance in Seattle, Washington; and
- Torture Victim Center in Minneapolis, Minnesota.

A. METROPOLITAN INDOCHINESE CHILDREN AND ADOLESCENT SERVICES (MICAS) (Boston, Massachusetts)

The Metropolitan Indochinese Children and Adolescent Services (MICAS) is a program of the South Cove Community Health Center. It provides mental health, child welfare, educational support, and social services to Cambodian, Laotian, and Vietnamese children, adolescents, and their families residing in the Boston metropolitan area. MICAS illustrates both the advantages of a specialized approach and the difficulty of maintaining funding for a targeted program of this type.

1. The Mental Health System in Massachusetts

The Massachusetts Department of Mental Health (DMH) is a statewide system of inpatient and outpatient mental health services. Major funding and programmatic decisions are made by the central office, with regional and area offices responsible for designing service approaches for their communities. Like many other states, Massachusetts recently

shifted its emphasis to the “severely and chronically mentally ill” as the priority population for funding.

Because Massachusetts is undergoing a serious fiscal crisis, funding for mental health and other social services is constrained. Severe cutbacks are expected. In previous years, however, when the state had a relatively healthy budget, it had expanded mental health initiatives in a number of programmatic areas, consistent with its long-standing tradition of commitment to the refugees, Because of the Governor’s personal interest in this population and the work of the statewide Governor’s Advisory Council on Refugees, efforts aimed at obtaining funding for services for new arrivals have been perhaps more successful than in other states and sources of political influence have been more sympathetic to refugee advocates.

2. **The Special Needs of Refugee Children**

Refugee children who have survived war and violence have unique service needs. Some arrive with serious and chronic health needs resulting from malnutrition, lack of adequate health care, and injuries of war. Others are mentally scarred by the trauma of fleeing political upheaval and armed conflicts. Still others have difficulty adjusting to their new lives in the United States. In response to the influx of refugee children, primarily from Southeast Asia, the Commonwealth of Massachusetts has developed some innovative specialized mental health programs, among them the Metropolitan Indochinese Children and Adolescent Services (MICAS).

3. **MICAS**

MICAS is a program of South Cove Community Health Center, a primary health care provider operating in Boston’s Chinatown since 1972. Primary funding for South Cove comes from Section 330 of the Public Health Services Act. The center’s primary client population are Chinese residents but is has provided services to Southeast Asians since they began arriving in Boston.

4. Services for Refugees

MICAS provides child welfare and mental health services to Cambodian, Laotian, and Vietnamese children and adolescents. Its services range from school and home-based outpatient adjustment counseling to intensive hospital diversion and inpatient psychiatric support. MICAS is the primary provider of mental health services for Southeast Asian youth in the Greater Boston Area. It also provides counseling for Southeast Asian runaways, teenage parents, and truants. With this broad range of services, staff are able to follow a client and the client's family through the complexities of the bureaucratic system without disrupting often delicate therapeutic relationships.

MICAS provides services across a wide geographic area. The central office is located in Chelsea, a community near Boston populated by Southeast Asian refugees. Satellite offices are located in four schools with significant Southeast Asian student populations and one community center in the Greater Boston Region.

In FY89, MICAS served 1 ,100 clients. Due to budgetary cuts resulting in the elimination of some services, MICAS will serve 450 clients this year. At present, these clients are served by 18 full-time staff members, including several Cambodian, Vietnamese, and Laotian bicultural workers. Central to its service delivery model is a cross-cultural team approach. Each patient and his/her family are assigned a Western clinician and a bicultural paraprofessional.

Team members work both together and independently, depending on the nature of intervention and the training level of the paraprofessional. An intervention with a suicidal adolescent, for example, would require sessions with the whole team, while counseling related to intergenerational conflict might involve only the paraprofessional worker who meets independently with the child and his or her family. In all cases, team members consult with each other regularly. A full-time clinical coordinator and a full-time clinical supervisor manage, supervise, train, and provide support for direct service staff.

Staff recruitment, development, and retention have always been priority concerns of MICAS. Three part-time consultants provide case consultation and training'to the program staff. They include a clinical psychologist and two licensed clinical social workers (LCSW), one with expertise in child welfare and one with expertise in English language training. MICAS uses pay incentives and promotion to encourage staff development through additional training and skills advancement. MICAS provides partial tuition reimbursement for staff members to pursue further education, and allows time off from work for those who attend training for paraprofessional counselors. It also offers an array of pre-service and in-service training for its staff.

Most of the bicultural employees participate in the Refugee and Immigrant Training Program offered by Boston University's School of Social Work. In addition to paraprofessional training, this program offers career counseling. Two Southeast Asian employees of MICAS have completed several cycles of the Refugee and Immigrant Training Program and are now working towards M.A.s in Community Psychology.

5. **Origin and Development of the Service**

MICAS was established in 1983. Despite the fact that the mandate of the South Cove Community Health Center was to provide culturally appropriate and affordable health services to the Chinese population of Greater Boston, the growing number of Southeast Asians arriving in Boston in the early 1980s caused the directorship to allocate resources to establish specialized mental health and social services for Indochinese children and their families.

The initial funding was provided out of the South Cove's general operational budget. In its first year of operation, the MICAS budget was approximately $50,000. The project also received support through the Federal Office of Refugee Resettlement (ORR) demonstration program (See Part I). In subsequent years, its funding sources diversified considerably and expanded. It operated with funds from the State Departments of Education, Social Services, and Mental Health as well as the Boston, Lowell, and Chelsea Public School Systems, two United Ways of Massachusetts, private foundations and corporations, and the

City of Boston. The cross-agency funding model provided a cost-effective method for state and city agencies to address the specialized service needs of a relatively small client population.

In the recent past, however, MICAS has suffered considerable budget cuts as a result of the fiscal crisis in Massachusetts. For example, in the last two years, the State Departments of Education and Social Services cut $80,000 of MICAS's $212,000 budget for its operation in Lowell. Currently, MICAS operates on a budget of $625,000. Additional cuts are expected. The mental health, child welfare, and drop-out prevention programs at Lowell High School were closed in December 1989. MICAS Program Coordinator Holly Lockwood said of this closure: "It means that there will be no services for the most vulnerable Southeast Asian families and children [who reside in Lowell]. We could not stay open and provide safe, quality service to our clients. It's an issue of scale. We are at a skeletal staff level now. We have only four people and we can't go lower than that."

6. Key Elements

The Metropolitan Indochinese Children and Adolescent Services successfully provides services to youngsters who are at risk of mental health problems. Beginning with a small budget, MICAS has significantly increased its programs over a seven year period. The effort is one of several examples in this handbook in which initial seed money from ORR or other sources allowed a program to "get a foothold" and solicit a more diversified funding base. Unfortunately, the tight fiscal situation in Massachusetts has begun to erode that progress.

The following factors have contributed to the successes of MICAS:

- Bicultural staff and the cross-cultural team approach provide appropriate communication for needs assessment, the ability to respond to varying levels of patients' acculturation, comfort for children and youth less familiar with the American culture, and most importantly, a link to parents and community.
- A program of staff development for bicultural workers with clearly defined stages, coordinated with promotions and pay increases.

- **Development of close relationships with mainstream mental and child welfare providers.** This entails collaborative service delivery --. allowing for delivery of culturally-appropriate, clinically-effective services to underserved, high-risk groups. This approach allows maximization of expertise, funding, and other resources.

- **Diversification of funding sources and cross agency funding of services,** a development that began with limited funding from ORR and private sources, but gradually grew into multiple funding sources,

- **Linkages with refugee communities** are essential to the responsiveness and credibility of the program. Participation in ethnic community events and celebrations has apparently built trust, mutual understanding, and cooperation between Western program staff and the refugee communities they serve.

B. THE SOUTHEAST ASIAN WOMEN'S ALLIANCE (Seattle, Washington)

The Southeast Asian Women's Alliance (SEAWA) was founded in 1984 by a group of refugee women who were interested in helping new refugee women resettle and avoid the difficulties others had encountered. The program has evolved to serve Cambodian, Vietnamese, Laotian, and other Southeast Asians as well as Ethiopian and Soviet women and their families living in the Seattle area. Although SEAWA's client base largely comes from the Ranier Valley where SEAWA is located, services are available to any refugee woman in need. The program does not provide acute and chronic mental health services; instead, SEAWA offers case management and family and domestic violence counseling programs to 80 to 100 families. SEAWA also supports preventive mental health programs that include: Even Start, a class on parenting and literacy; English as a Second Language classes; an Employment Awareness course; parenting classes; and support groups. These programs serve between 175 and 200 women a year. In order to enable women to take advantage of the center's programs, SEAWA also provides day care services for approximately 45 children per day. Bicultural women both provide services and serve on SEAWA's board of directors.

SEAWA illustrates the potential for a preventive mental health approach in the context of focused self-sufficiency services for a relatively small clientele. Although the program addresses refugee mental health issues and problems, SEAWA's broader mission is to help refugee women achieve self-sufficiency,

1. Refugee Mental Health Services in Seattle

The King County Mental Health Department supports two programs that provide chronic and acute mental health services for refugees, including the Southeast Asian Counseling and Referral Services program and Refugee Mental Health Services that serve non-Asian refugees. Refugee clients who wish to access the services of these programs, however, typically must wait approximately three months before they can obtain care. SEAWA utilizes the Southeast Asian Counseling and Referral Program for consultation purposes as well as for training staff. Refugee women have special needs in terms of mental health services. These needs are related to their experiences as refugees (for example, rape and sexual harassment) as well as to their responsibilities for child care. The fastest growing need for SEAWA's assistance are for counseling and mental health services, with an emphasis on family counseling services. The need for family counseling is especially acute due to the intergenerational conflict arising when children, primarily teenagers, do not observe cultural traditions and parents become angry and frustrated.

2. Scope and Mission of SEAWA

SEAWA's center is located in public housing space. The space is provided to the organization rent-free, and is run-down and cramped. The center has two large classrooms, two small child care rooms, one bathroom, and no kitchen, and no storage space. The center's two offices are also used for counseling clients. Improving the facility and acquiring new space is one of the center director's top priorities.

Although all the day care services and practically all of the educational courses are on-site, many of the counseling and case management activities take place in a range of settings that includes clients' homes and other public agencies. It is reported that even though some clients do not initially seek counseling services, in the process of receiving other services, they reveal the need for counseling. In particular, case managers note that clients often tend to discuss their problems while being driven to appointments or when filling out paperwork.

In 1989, SEAWA's operating budget was $125,000 with approximately 10 percent coming from the state Office of Refugee Assistance, 20 percent from the county, and 40 percent from a Department of Social and Health Services Minority Mental Health Grant. The remaining funds come from a number of other smaller grants with approximately 1 percent of the funds secured from community fundraising efforts.

Twenty women, including volunteers, provide services to SEAWA's clients. Staffing has been one of the center's major problems since SEAWA lacks the financial resources to hire highly qualified staff and must compete with other organizations such as the state Health Department in recruiting employees. This problem is exacerbated by high staff turnover and considerable on-the-job training required for new staff. The program's experience indicates that young refugees who have gone through the local university system are highly effective in working with the refugee clients, These individuals, unlike older refugees, are able to provide a. better bridge between the clients' traditional culture and American culture.

All of SEAWA's salaried staff, with the exception of the Director and one of the day care workers, are bicultural. The staff includes: two part-time English as a Second Language teachers and two part-time parenting instructors who are paid by the local community college; five community volunteers; the program director; the program manager, who also serves as a counselor; two full-time counselors; two part-time day care workers; three part-time bilingual assistants; and one quarter-time financial manager.

The counselors are available five days a week from 8:30 a.m. to 4:30 p.m.; day care services are also provided during this time. Classes are offered four times a week and last for three hours. The volunteers have not been actively recruited; instead, they approached the agency director expressing their interest in volunteering at the center. Due to the lack of a volunteer coordinator, volunteers are given autonomy in deciding what role to play in the agency. To date, this approach has worked well; however, the center only uses about five volunteers at any one time.

3. **Service Approach**

Overall, the approach taken by the center is intended to build clients' self sufficiency, confidence, and independence. This philosophy is incorporated into the center's counseling activities in that SEAWA seeks to provide supportive, non-directive counseling. Counselors try to help clients make their own decisions and support them in carrying out these decisions. The center employs bicultural staff who receive their counseling training through the center and through consultation with Southeast Asian Counseling & Referral Services.

The classes and day care programs are also intended to build confidence and independence by helping to teach women communications, employment, and assimilation skills, such as how to deal with a new culture and value system. These programs are also intended to avert intergenerational family conflicts and ultimately benefit children since SEAWA's hope is that children with self-sufficient parents encounter fewer problems. For example, the day care program includes educational activities considered to be comparable to Early Childhood Education programs.

For case management, SEAWA draws upon the resources of other social service agencies and programs in order to coordinate the delivery of necessary services. This work encompasses working with WIC, Food Stamps, and Medicaid programs as well as the public housing and school authorities, and the legal and child welfare systems,

4. **Origin and Development of the Service**

SEAWA began as a grass-roots organization in 1984 by a multi-cultural group of refugee women who wanted to help refugee women settle and avoid some of the problems others had encountered. This group eventually asked other mainstream women's service organization representatives to join their group in an effort to obtain new sources of funding.

In 1985, King County Women's Program awarded SEAWA a $10,000 grant which was matched by a state Office of Refugee Assistance grant. As a result, SEAWA had a

$25,000 operating budget in 1985 with which it provided, counseling, English as a Second Language courses and on-site day care. As noted above, it operates in a rent-free center and the local community college provides the funding for the center's English language teachers.

In 1986, the center received a $50,000 demonstration grant from the Federal Office of Refugee Resettlement (ORR), which allowed it to expand the program to three educational classes, including an employment awareness program, and improve its day care program. During this time, the day care program changed from a cooperatively provided service where women alternated watching each other's children, to a fully staffed day care program. This change was undertaken largely because women came to SEAWA to study English and were not interested in watching children, This change was also made so that SEAWA could provide a quality education program for the children.

The program has continued to receive grant support at increasing levels, 1989 was the first year that the center's budget was able to fully pay the director's salary. In spite of the program's increased funding, SEAWA continues to be understaffed and underfunded with one telephone and no support staff for the entire center. In the past, the program's funds had been depleted before all the staff could be fully compensated. Still, clients have not been turned away.

The program has a board of directors that continues to consist primarily of refugee women. Nonetheless, SEAWA has recently sought to bring in more board members who possess the business skills needed to enhance its fundraising activities.

The more significant probfems SEAWA encountered in its first six years of program development and operation include:

- **Funding,** which continues to be SEAWA's most serious problem. Since the program does not provide acute or chronic mental health services, it is not eligible for Medicaid or Medicare reimbursement. In addition, although the program helps to develop employment skills, it is not a job placement service, thus limiting the sources of funding from other government entities. Also, while the program has been successful in obtaining grants, it is a difficult and time

consuming task to sustain. The program has also experienced some success with community fundraising efforts but this has proven to be highly time consuming. Community fundraising efforts have, however, served as useful public relations activities.

- Recruiting **and maintaining qualified staff** has been difficult given limited program funding. In general, SEAWA has found that the younger, university educated bicultural women are more effective, but they also have higher rates of turnover. In order to address this problem, SEAWA requested that applicants make a one year commitment to work at the center; to date, no college graduates have agreed to this stipulation.

- **Board development** also has been a time consuming process. However, SEAWA's Director believes these efforts have paid off in that the board has served a very important role in SEAWA's planning and decision making. SEAWA's Director also noted that they are seeking to enhance their board. SEAWA has sought other non-refugee members with fundraising, management, and political skills and contacts to improve its fundraising. Although the program director feels it important to empower refugee women in these, as well as other, positions **in the center; others at** SEAWA feel that many of **the** women are already overburdened and need outside participation on the board.

5. Key Elements

The Southeast Asian Women's Alliance has met with considerable success in meeting the needs of its clients while continuing to face financial and staffing difficulties. Its persistence in maintaining a service capacity in light of funding constraints makes it a model for others.

The following include some of the factors that contributed to SEAWA's success:

- **The community support and spirit of volunteerism** were critical to the successful founding of the program. Having rent-free use of their facility and English teachers from the local community college were most helpful. In addition, volunteers continue to provide a valuable source of staffing.

- **Providing necessary preventive mental health and support services that could not be offered elsewhere** has also made SEAWA unique. For instance, most of these women did not leave their homes before being introduced to the program since their husbands would assume responsibility for doing the shopping and other errands. Most women did not even know where their children went to school. The educational courses have helped these women to

become less isolated and more functional **in their** new society. The day care skills have also been important since many of these women would otherwise be prohibited from taking advantage of the center's programs due to the lack of alternatives or their not knowing how to access day care services elsewhere.

- **Community education programs** in which class members discuss family and community living problems appear to be successful in helping the refugees to adjust more effectively to their new environment. These interventions are intended to promote adjustment to the new culture and help refugees resolve intergenerational conflicts, thereby serving to prevent mental health problems.

- **Need for a broader and more stable funding base** has been largely overcome by the sheer persistence and dedication of the SEAWA staff and board. This has been a continual problem, however. While the model and program design is replicable, SEAWA's director feels that other providers should consider seeking an umbrella organization as a sponsor to avoid the problems associated with not having a regular funding source. More specifically, a similar program could be operated through a health organization, an English as a Second Language program, a mental health agency, or through a school system.

C. THE TORTURE VICTIM CENTER (Minneapolis, Minnesota)

The Center for Victims of Torture, a private non-profit organization supported by contributions of individuals and private foundations, provides rehabilitative treatment for victims of torture and their families. Torture victims are defined as survivors of deliberate, intentional and systematic infliction of pain and suffering, either physical or mental, at the hands or the instigation of public officials or others in positions of authority, to extract confession, punish, or intimidate people.

The Center illustrates a specialized service agency that focuses on some of the most needy refugees in terms of mental health services. It also demonstrates changes that can be made in encouraging new groups, such as human rights organizations, to develop interest in mental health issues affecting refugees.

1. Mental Health Services in Minnesota and Minneapolis

The Torture Victim Center fits into a mental health system that is largely decentralized. Counties provide a substantial share of the funding for mental health services and are responsible for designing service approaches for their communities, The state makes general funding and programmatic decisions, and, as seen in the case of the Torture Victim Center, can promote the need for greater attention to specific problems or populations.

2. Torture Victim Center

The Torture Victim Center was established in 1985 with the following mandate:

- To provide treatment to survivors of torture by foreign government;
- To serve as a link to local and worldwide community of concerned persons; and
- To provide research toward effective treatment and prevention of torture.

Because torture affects so many of an individual's capacities, rehabilitative treatment at the Center has been conceived as a multidisciplinary effort, including such disciplines as medicine, psychiatry, psychology, and social work. All services are provided on site, in a small, comfortable house decorated with artwork familiar to those groups using the Center's services. The Center is associated with a health facility where physical symptoms can be treated as needed. Some clients prefer the clinical health setting for receipt of services. The Director of Psychiatric Services at the International Clinic at Ramsey Hospital is a senior staff member at the Torture Victim Center.

The rehabilitative services provided by the Center are offered on an outpatient basis. They consist of medical evaluation and long-term medical care, psychological assessment and psychotherapy, psychiatric evaluation and pharmacotherapy, social services, and client advocacy. In addition, the Center offers legal assistance through a cooperative agreement with the Minnesota Lawyers International Human Rights Commission. The client's attorney often becomes an important "external" member of the rehabilitation team, particularly

when obtaining political asylum in the U.S. is a priority and a precondition for long-term treatment interventions, such as psychotherapy.

The Center's clients come from 21 countries, with Ethiopia being the most frequent place of origin, followed by Latin America, the Middle East, and Eastern Europe. The clients include individuals who came to the United States through the refugee resettlement program as well as those who came to this country on their own. Among the latter are clients who have applied for or been granted political asylum. There are also a few cases of Holocaust survivors and U.S. citizens tortured abroad. Center clients range in age from 18 to 51. Approximately one-fifth are women. Almost one-fourth of the Center's clients were tortured as children, Most of the clients are capable of communicating in English or are Spanish-speakers.

The Center is staffed by psychiatrists and psychologists. The first director of the Center had been director of the Sexual Violence Center in Minneapolis and served as a consultant on corrections, family violence, chemical dependency, andsexual abuse. Faculty and students at the University of Minnesota, particularly those affiliated with the Refugee Mental Health Technical Assistance Center, contribute to the activities of the Center. The most recent addition to the staff is a full-time social worker. Originally the management thought that the clients' social work needs could be met at the existing agencies in the community. However, this has not been the case, partly because many of the Center's clients have multiple needs that are best met in a coordinated manner. There are plans to add a nurse and a physiotherapist.

The multidisciplinary orientation extends beyond the staff to the groups that assist and support their endeavors. Both the Center's Board and its Treatment Committee are staffed by professionals from the community, representing each of the above-mentioned disciplines.

3. Origin and Development of the Services

The Center was established in 1985 following the recommendations of a blue ribbon commission appointed by the state governor. The commission consisted of religious leaders, political and business figures, and leading health professionals. The Commission recognized that torture is a widespread problem, with Amnesty International reporting torture or ill-treatment occurring in 98 countries. A study in Minnesota had documented that as many as **60 percent of refugees** seeking treatment had been victimized by torture.

The commission recommended establishing a torture victim center with the following mission:

> To provide rehabilitative treatment for survivors and their families, contribute to research toward the development of effective treatment approaches, provide information, education and training, and work toward the prevention of torture itself.

The recommended center was to be patterned after programs established in Copenhagen and Toronto for victims of torture. The experience of the other centers showed that victims of torture are often plagued by lingering terror, humiliation, stress, and extreme physical pain. For these victims, psychological and medical problems were found to exist independently of other problems involved in adjustment to a new society. In addition, victims of torture were found to have similar problems, regardless of nationality. The Center, therefore, determined from the outset to serve whatever nationality groups presented themselves.

A number of factors played an important role in the inception of the Center:

- **Size of the refugee population.** The Twin Cities area has a very high proportion of refugees (35,000-40,000 refugees) relative to its size. The area has generally been recognized as sympathetic to the situation of refugees and generous in its welcome of the newcomers.

- **Liberal and comprehensive health and social services.** The state is well-known for its liberal policies regarding health, mental health, and social services. Health care services are rated among the highest in quality in the country. The fields of medicine and psychology in the state, in particular, have had a strong tradition of significant contribution to both research and practice.

- **Strong interest and support for human rights work.** There has been strong interest and support for human rights work in Minnesota, and there are several organizations in the state, such as the Minnesota Lawyers Committee for Human Rights and the Center for Human Rights at the University of Minnesota, that are very active in this field. The Center has received support from foundations that have made issues related to human rights a priority area.

- **Support of voluntary agencies involved in the resettlement of refugees.** Minnesota is the home of several church-based voluntary agencies active in the resettlement of refugees from all over the world. There are also smaller religious groups concerned with the issues of social justice and world peace, such as Sanctuary movement groups which have been especially interested in the plight of victims of organized violence from Central America.

The combination of these factors resulted in a community which is knowledgeable and sensitive to the problems refugees face in their resettlement in the United States and to more general human rights and social justice issues. This community was in turn responsive to the idea of establishing a specialized center for torture victims.

Although its establishment was recommended by a public commission, the Center itself sought funding and support from the private sector. A $300,000 grant from the Northwest Area Foundation provided the initial resources for its operation. Additional foundations have since provided support.

4. Key Elements

The Torture Victim Center provides mental health services to some of the most needy refugees -- victims of torture. The effectiveness of the Center can be attributed to its expertise in providing mental health services to this special population as well as the interdisciplinary approach it follows. Some of the functions contributing to the Center's success are:

- **A full-range of mental health and social services** that address the multi-faceted problems that victims of torture face. The program is based on the assumption that torture victims have physical, mental, social and other problems that have resulted from their experience. The core disciplines in their approach are medicine, psychology, psychiatry, and social work. The model is one of rehabilitative treatment aimed at helping clients solve current life problems. Both pharmacotherapy and psychotherapy are used.

- **Linkages with a variety of other groups concerned with their clients.** Linkages with legal human rights groups have had a therapeutic benefit both in helping to address issues related to legal status and the causes of torture and in opening up new funding sources and support for the Center. Linkages with a university program have provided staff, consultants, and expertise. Linkages with health facilities have allowed physical symptoms to be treated.

- **Strong potential support and a receptive community that** stimulated the founding of and continued support for the Center. This support began at the level of the governor. It also included foundations and other founders.

- **A well-designed approach** that builds on the successful operation of Torture Centers in other cities. The Center in Minnesota had a clear sense of what differentiates torture victims and based its services on this understanding. For example, well-informed decisions are made about the location of the Center, treatment strategies, and even the timing of appointments to reassure and calm torture victims.

CHAPTER FIVE:
THE MOBILE TEAM APPROACH

The mobile team, established by the Asian Community Mental Health Services in Oakland, California, provides clinical consultations and appropriate training to small counties lacking the resources needed for specialized refugee services. It also provides emergency technical assistance, the most tragic but successful example of which was the mobile team's involvement in Stockton, where a deranged gunman killed several Southeast Asian children at a local elementary school. The mobile team was funded by the State of California, through the RAP/MH program. This case study illustrates an innovative approach to delivery of mental health services in communities with too few refugees to justify the hiring of special staff or establishment of special programs.

A. THE CONTEXT

California has the largest proportion of Southeast Asian refugees of any state in the United States. Mental health services for this group began developing in the mid-l 970s in larger cities, particularly San Francisco, San Diego, and Los Angeles. Only San Francisco and Los Angeles have a complete range of mental health programs -- including specialized inpatient units -- offering culturally appropriate mental health services to Indochinese refugees. While some counties, such as Sacramento, have had a fairly stable refugee population, a number of others have experienced a rapid influx of refugees in the 1980s.

The RAP-MH-sponsored needs assessment studied 10 of California's 58 counties (those most heavily populated by refugees) and found that some services were provided entirely through interpreters; some counties had no mental health services other than prevention and outreach programs; and even outpatient services in larger counties were limited. In the 10 counties, 83 bicultural paraprofessionals, most of whom have no relevant mental health academic training, were working in mental health programs. Only one of the counties had a Southeast Asian on the local Mental Health Advisory Board.

B. SERVICES OFFERED

For logistical reasons, the mobile team was to serve only Northern and Central California. At the initiation of the project, all county mental health directors in the northern and central regions were sent a letter introducing the project. Follow-up phone calls were made to counties where no previous contact had been made (via activities of the first two years) with the county. Of the 14 counties contacted, nine expressed interest in receiving clinical consultation services and seven requested training.

During the 14 months of the mobile team's operation, on-site clinical consultations around specific cases or types of cases occurred in 7 counties, serving 62 clients; phone consultations were provided to discuss 15 cases. Non-clinical consultations were provided to 90 mental health clinicians on such topics as cultural differences in viewing mental illness, community outreach, available resources, and staff development. Toward the end of the third-year requests for clinical consultations increased substantially; as a result, a new format of a one-day training session with a resource packet replaced the more tailored consultation model.

The staff of the mobile team consisted of a Chinese-American licensed clinical psychologist and three bicultural paraprofessionals. The mobile team had bicultural capability in Vietnamese, Lao, Mien, and Cambodian. In midyear the clinical psychologist left the agency. After that point, clinical consultation was provided on a contract basis by several other San Francisco Bay area psychologists.

Funding for the mobile team came entirely from the California RAP-MH budget. The California Department of Mental Health used the RAP-MH funds to contract with Asian Community Mental Health Services in Oakland. The 14 months of the mobile team's operation cost a total of $175,000. No funds were available to continue the program after the RAP-MH project ended. Individual counties have, however, continued to purchase consultation from clinicians they met through the mobile team project.

Halfway into the project year, a deranged gunman shot and killed five Southeast Asian refugee children and wounded many others at the Cleveland Elementary School in Stockton. The mobile team mounted a concerted effort to assist local mental health and refugee agency staff in dealing with the traumatic effects of this attack. A separate case history presented in Exhibit 5.1 details the mental health response to the Stockton incident and the mobil team's role in that response.

C. HOW THE SERVICE GOT STARTED

The clinical director of the California State Department of Mental Health, an Asian, was involved in the original NIMH-sponsored meetings that led to the development of the RAP-MH program. From that first conference of refugee clinical specialists, he had returned with the idea of a mobile clinical team that could, from a centralized location, provide technical assistance to small counties lacking the resources necessary for specialized refugee services. The state Department of Mental Health contracted with the Oakland-based Asian Community Mental Health Services to perform the needs assessment, required under the RAP/MH program. ACMHS also carried out'training programs as part of the RAP/MH program and established a mobile team in the third year of its operations.

D. KEY ELEMENTS

The Mobile Team demonstrates that mental health services can be provided to refugees in counties with small numbers of newcomers. As an approach, the Mobile Team also appears to be an effective way to respond to a crisis situation.

The experiences of the Mobile Team indicated that:

- **A mobile clinical consultation model can sensitize mental health professionals** to the need for bicultural staff. Three of the counties assisted by the mobile team were influenced to hire bicultural paraprofessionals.

- **Staffing a mobile team is difficult.** Demand is not consistent enough to permit hiring staff who only work on the team. Thus, a parent agency must agree to "lose" some of its staff at unpredictable times. Scheduling as well as

Exhibit 5.1

THE STOCKTON INCIDENT AND THE MOBILE HEALTH TEAM

On January 17, 1989, Patrick Purdy, a deranged gunman, sprayed bullets across the playground of the Cleveland Elementary School in Stockton killing five Southeast Asian children enjoying their morning recess. Purdy's bullets struck children of various races and ethnic groups. But because four of the slain students were Cambodian, one Vietnamese, and the majority of the 29 injured also Southeast Asians, Purdy's 106 rounds of fire ripped into the psyches of refugee groups who had already suffered some of the worst mass atrocities in recent history.

Fear and depression dominated the first hours, days, and weeks after the tragic event. Many Southeast Asian parents were numb with grief and shock. Most of them had already lost spouses and children in Cambodia and Vietnam. After the shooting, they reported flashbacks of past horrors, sleeplessness, lack of appetite, hallucinations, withdrawal, anxiety, and depression.

The children were frightened too. At the hospital, one wounded Cambodian girl became so terrified that she didn't utter a word for more than 24 hours. Not until a psychologist and Cambodian paraprofessional talked to her in her own language and asked her to draw pictures did she feel secure enough to talk again.

To deal with all of these problems, the Stockton Unified School District brought in the Clinical Director of the California State Department of Mental Health and the Oakland-based Mobile Team. The Mobile Team's strategy was community-wide. During the weeks after the tragedy, almost everyone connected with the shooting -- school staff, ambulance drivers, paramedics, emergency room workers, firefighters -- received "psychological debriefings" or group counseling. The Mobile Team was particularly concerned that Southeast Asian refugees would experience flare-ups of the little understood Post-Traumatic Stress Disorder (PTSD), thought to be a lifelong condition that waxes and wanes. School psychologists monitored children during the critical period of eight weeks after the shooting, during which PTSD symptoms could first be expected.

The Mobile Team knew that Southeast Asian communities such as the one in Stockton lived in isolation and were not aware where mental health services were available. The morning after the shooting, families of all five slain children were summoned to the county mental health center and assigned case workers to help with funeral arrangements and other practicalities. School psychologists, public health nurses, and social workers monitored families of the wounded children. Refugees whose children escaped physical harm were also sought out. Mental health workers scattered throughout the refugee neighborhoods distributing fliers in Vietnamese, Cambodian, Lao, and Hmong. The fliers provided information about a multilingual hotline and the Transcultural Mental Health Clinic.

The Mobile Team staff believed that unlike their parents, Cleveland school youngsters would benefit from immediate counseling. The children were more expressive and generally experienced fewer traumas, although older ones might have witnessed violence in refugee camps. In small groups, the children talked. Those with limited English drew pictures about their feelings and fears.

The Mobile Team personnel stayed in Stockton into the month of March. A total of six staff provided services to the Southeast Asian refugee community, the school system, and the county mental health system. Provided services included: counseling of the injured children, families of all victims, school personnel, and other school children; consultation to the mental health system on culturally appropriate services; and assistance to the mental health and school systems with community outreach.

cost-accounting problems arise. In addition, the cost of hiring clinicians is high. If clinicians are brought in on a contract basis, they can require high fees as a condition of their willingness to respond quickly.

- **Client-focused clinical consultation and tailored technical assistance and training are needed.** A mobile team must have the staff flexibility built in from the beginning to permit responding to either kind of request.
- **involving the local MAA in the consultation** helped in one county to integrate the MAA into the county service system, thus improving overall refugee service delivery. In effect, close consultation with key members of the refugee community served a dual purpose of helping the mobile team in its response to the community while improving the linkages between the MAA and the county service system.

- **Individuals with experience in small rural counties** must participate in the mobile team. Mental health services in rural areas are so different in these counties that the advice of consultants only familiar with urban service systems is of limited value, One secondary effect of the mobile team was to create a small cadre of refugee mental health consultants who now have become familiar with conditions in small counties.

PART III:

LESSONS FOR LOCAL EFFORTS

PART III:
LESSONS FOR LOCAL EFFORTS

This chapter offers guidelines for the local advocate or program administrator seeking to establish effective mental health services for refugees. The guidelines are drawn from the previous case studies and our evaluation of the Refugee Mental Health Initiative (RAP-MH). The guidelines are organized under four headinps:

- Building Support for Refugee-Specific Services;
- Designing the Program;
- Financing the Program; and
- Staff Recruitment and Development.

An overview of the guidelines is provided in Exhibit III.1. An index, linking these guidelines to actual case study examples from Part III, can be found at the end of the Introduction to this handbook.

A. BUILDING SUPPORT FOR REFUGEE-SPECIFIC SERVICES

The programs described in this handbook demonstrate the need for concentrated efforts at the local level to build support and funding for refugee-specific services. Common to each of the case studies was a focused, agency- and program-specific effort to obtain a commitment to increased availability of culturally relevant services for refugees. Commitment was obtained from policymakers, funders and other service agencies, as well as from the refugee community. This section suggests six avenues for developing local support for refugee-specific services.

Exhibit III.1

OVERVIEW OF GUIDELINES FOR LOCAL EFFORTS

A. BUILDING SUPPORT FOR REFUGEE-SPECIFIC SERVICES

- Develop alliances with other programs and agencies.
- Draw on advisory groups and boards for support.
- Build support within the refugee community.
- Build support internally.
- Make strategic use of information.
- Promote a better understanding of refugee needs in the state mental health system,

B. DESIGNING THE PROGRAM

- Rely on non-psychiatric settings when possible to avoid stigma problems.
- Develop an appealing and non-threatening clinical environment.
- Use a multidimensional treatment approach.
- Encourage a team approach between bicultural and professional staff.
- Ensure coordination and linkages with other service systems.

C. FINANCING THE PROGRAM

- Focus on establishing service capacity, regardless of initial size.
- Cultivate diversified funding sources, relying on neither one type of funding nor one type of service.
- Maximize Medicaid payments.
- Maximize other third-party billings.

D. STAFF RECRUITMENT AND DEVELOPMENT

- Ensure that bicultural staff hired into mainstream positions are well-regarded within the local refugee community
- Recognize and make accommodations for the "dual role" of staff as refugee leaders and bicultural workers
- Encourage a sense of professional development and autonomy for bicultural staff
- **Sponsor in-service training for staff**
- Encourage advanced training for existing bicultural staff

1. Develop Alliances With Other Programs and Agencies

The refugee community in most locations is small in number. Making the argument for changes in policies and advocating for increased expenditures on behalf of a small group is typically difficult. One way to overcome this challenge is to forge coalitions with other groups in need of similar improvements in mental health services. By going to policy makers and funders as part of a larger constituency, refugee advocates increase their prospects of obtaining change. They also increase the range of services available to their clients by forging alliances with other service providers to whom they can refer clients,

The first step in building external support is to identify potential allies, Three types of allies stand out:

- **Institutions affected by the presence of mental health problems among refugees.** For example, school counselors often encounter emotional problems among refugee students; police departments apprehend refugees who are demonstrating the effects of Post-Traumatic Stress Disorder; and employment services have difficulties in referring emotionally disturbed refugees to jobs. Other groups lending support to several of the programs in this handbook included the courts, corrections departments, and public health agencies.

- **Groups representing other disadvantaged populations.** Refugees are not the only group facing obstacles to mental health services. Organizations concerned with minorities and other limited English speakers may also be working on changes in policies that will make mental health services more accessible to their populations. They may also have specialized services that are useful to refugee clients, particularly if translation is provided.

- **Groups concerned with other victims of trauma.** Other victims of trauma face difficulties in gaining access to mental health services and may be lobbying for improvements in services to respond to Post Traumatic Stress Disorder. These **persons include rape victims, victims of other violent crime, hostages, and veterans who have experienced the trauma of war.**

- **Advocacy and consumer groups involved in lobbying** for improvements **in mental health policies and programs.** This type of ally was used effectively in Massachusetts, where the Refugee Task Force on mental health joined the Massachusetts Association of Mental Health in order to maximize their advocacy efforts, Most national advocacy and consumer groups have local affiliates. It may be beneficial to check local listings of associations and to

consult the yellow pages to learn about their activities. Meeting with a United Way official or seeking others with connections to these organizations can facilitate the creation of a network of committed individuals.

In a number of cases, agencies augmented their capacity to build alliances by broadening their own client focus. The benefits of having many constituencies was particularly evident for the Pan Asian programs. The San Diego and Colorado Pan Asian efforts both started with single ethnic groups but intentionally broadened their focus both to build political support and to pool advocacy efforts and resources. These and other Pan Asian efforts in communities with large Asian populations now constitute some of the most firmly established and best-funded programs in the country. Similarly, some of the cases involved collaboration and joint services on behalf of multiple Southeast Asian populations. In contrast, at least two separate groups in Sacramento (one Southeast Asian and the other comprised of other Asian groups) have resisted coalition efforts and as a consequence have only been able to establish minimal referral services for their clientele.

2. **Draw on Advisory Groups and Boards for Support**

A second step is to identify potential allies for advice and support. This can be accomplished through the strategic use of advisory groups, The Zumbro Valley "New Hope" program, for example, established a Refugee Task Force to monitor and help facilitate growth of their new program. The Task Force is comprised of representatives of most organized groups in Rochester serving refugees, including the local MAA, the health department, the voluntary resettlement agency, the public school system, the public welfare office, the police, and the courts. The CUHCC refugee service in Minneapolis similarly worked actively with local service agencies.

Advisory groups can help:

- **Build understanding and support of the need for mental health services,** sometimes resulting in direct and tangible support. As a result of advisory group interaction with the Minneapolis CUHCC program, for example, the Minnesota Health and Human Services Agency provided the clinic with funding for child abuse and sexual assault counseling. Likewise, the "New Hope"

program was able to persuade the local school system to provide support for student counseling.

- **Temper competition for scarce funding by coordination of solicitation efforts.** Some of the cooperative efforts resulted in agreements among the agencies on funding priorities or joint service strategies which enabled them to make reduced or complementary funding requests to local agencies. In Colorado, the Asian/Pacific Center for Human Development signed agreements of understanding with local mental health agencies that the Center would provide services to all monolingual Asians in the Denver metropolitan area.

- **Mobilize other service providers** to assist more actively in the refugee adjustment process, The Task Force efforts in Rochester, for example, resulted in more active and focused efforts by the county financial assistance office to identify and refer refugees in need of special adjustment assistance. The financial assistance office has become a skilled partner in directing refugees to the "New Hope" program and other service agencies as needed.

Some of the more successful programs have also been very strategic in selecting and drawing on their boards to educate the community and consolidate support for their programs. The Denver Pan Asian program, for example, selects board members who are not only representative of the various Asian communities but those who also possess particular supportive skills (e.g., legal, fundraising, entrepreneurial, etc.). The Center also took steps to ensure that the board members had responsibilities that corresponded with their interests and capabilities. When the program diversified organizationally, board members interested in programmatic design and administration retained their ties with the operational entity, and board members more interested in and skilled at fundraising devoted their efforts to securing resources for the new foundation. The director feels this "specialization" has helped energize board members by matching responsibilities with personal and professional skill areas.

For several of the programs, influential and/or knowledgeable board members played pivotal roles in gaining program support. In San Diego, for example, a university professor helped enlighten public officials regarding the needs of refugees and generated support for increased public funding. In Rhode island, the influence of the chairman of the Governors' Advisory Council was used to secure allocation of funding for the Southeast Asian Support Center at St. Joseph Hospital.

3. Build Support Within the Refugee Community

Support from the refugee community is often critical. In addition to building political momentum and support for new services, support from the refugee community also provides for important input on program staffing and design. Moreover, efforts to inform the refugee leadership of a new program can help them buy into the process and become sources of referral. In the absence of leadership support, many refugees may be unlikely to use the service.

One of the lessons learned by the Lowell Mental Health Center occurred when the Center almost hired a Cambodian worker who appeared qualified and compatible with current agency staff, but was not rooted in the local community. Several groups (including the Massachusetts RAP-MH staff) intervened to point out that refugees would not be likely to use the service if the staff involved were not known and trusted members of the community. As a result, the Center assembled a selection committee with representatives from the local MAA to help in the hiring process.

In contrast, the CUHCC mental health staff spent considerable time laying the groundwork within the refugee community before instituting the new bicultural service there, seeking input on program design and staffing and ensuring that a thorough understanding of the proposed service was developed. Staff at CUHCC feel that these efforts have been vital to ethnic community support for and use of the clinic.

4. Build Internal Support

Where bicultural capability has been introduced into mainstream programs, considerable attention has been devoted to educating and working with mainstream staff to ensure acceptance and support. In several of the cases, this practice has clearly been beneficial. American-born professional staff are often wary and uncertain about the role of bicultural paraprofessionals, and sometimes ambivalent about how much authority they should be accorded. Once clinical staff understand the value of bicultural assistance, however, they can become a program's most enthusiastic proponents. In Lowell, for

example, internal support among both administrative and clinical staff developed gradually, eventually catching the attention of the regional director and influencing her efforts to seek resources for expanded bicultural services.

Programs have generally facilitated this internal support by viewing the relationship between bicultural paraprofessionals and professionals as a "two-way street." The biculturals, of course, need training and guidance from the professional staff. Similarly, the professional staff can learn from the biculturals through such vehicles as presentations on the refugee experience, seminars on traditional healing methods, and joint therapy **sessions. Indeed, refugee staff can also benefit from the mainstream staff's interest** in their experience. A turning point in the esteem and respect accorded to the bicultural worker in one mainstream mental health center was apparently reached when he hosted a slide show on his background.

5. Make Strategic Use Of Information

Information is a powerful tool in building support for mental health services for refugees among policy makers and funders. In part, this information can come from the refugee needs assessments that were conducted as part of the RAP-RAH initiative. It is not enough to collect information about needs, however; it is equally important to develop a targeted information dissemination plan. Most of the programs in this handbook began their efforts by deciding who needed information about refugees. They then focused their efforts on that audience, drawing on selective, existing information about refugee needs -- much of it anecdotal:

- In Denver, the Pan Asian advocates focused their educational efforts on a sympathetic senator, pointing out the parallels between refugee needs and needs of handicapped populations.
- In San Diego, the Pan Asian community spent much time explaining refugee issues and problems to key county representatives.
- In Fresno, a breakthrough came when a service advocate had lunch with the County Executive who would be influencing the appropriation of surplus rollover funds.

- In Rochester, the local MAA explained to Community Mental Health Center staff the adjustment problems emerging among employment service. clients; similar information was later used by both the mental health center and the MAA to obtain state funding.

- In Lowell, the Massachusetts RAP-MH director used mostly anecdotal information about Cambodian needs to convince the Community Mental Health Center director to hire bicultural staff.

- In Lynn, the health center director gradually and quietly informed local officials about her refugee program to pave the way for possible local funding to replace state cutbacks.

These examples do not indicate that formal needs assessments are unimportant; they are, however, in and of themselves insufficient. In fact, one of the clear benefits of the RAP-MH Initiative is the detailed array of information now available on the mental health needs of refugees and barriers to gaining access to services. Other states and localities may borrow from this body of literature, most of it having applicability regardless of geographical location (e.g., many states have used California's thorough needs assessment). While specific information from your locality may buttress your arguments, it will not be necessary to do a full-fledged needs assessment to make the case for improvements in mental health services for refugees.

What does appear to be important, however, is the strategic use of information. n most of the successful efforts noted, specific individuals and organizations were targeted for education, and the information was focused to make the case to that particular audience.

6. Promote A Better Understanding Of Refugee Needs In The State Mental Health System

Many of the RAP-MH initiatives raised awareness and understanding of refugee mental health needs, While this heightened awareness did not by itself result in new or improved services to refugees, it sometimes enforced the credibility of locally directed efforts to obtain special funding. In Massachusetts, for example, the state regional office director for the Lowell area was responsive to and interested in efforts by the Lowell Center to obtain bicultural eligibility. This was in part due to the efforts of the. RAP-MH program (located in the

Central office) which had worked hard to inform state mental health personnel of the unmet needs of refugees.

Some states have already committed to maintaining RAP-MH staff, in part to continue this effort of educating providers and others within the system. Other avenues for raising awareness in the system include seminars, conferences, advisory groups, and other forms of dialogue.

B. DESIGNING THE PROGRAM

As earlier chapters in this handbook demonstrate, a range of vehicles have been used at the local level to enhance refugee access to mental health services, including specialized clinical services; bicultural capacity in mainstream health and mental centers; and improved referral, counseling and treatment capability in ethnically-based service agencies. Regardless of which strategy is pursued, several design lessons emerge from the case studies, This section describes these lessons. As noted earlier, we have not attempted to offer guidance on clinical approaches to therapy for refugees, an area that has been well covered by publications of the TAC. Rather, our focus is on general elements of program design that appear to have contributed to success in current mental health efforts. Five guidelines are offered as follows.

1. **Rely on** Non-psychiatric **Settings** When Possible **to Avoid Stigma**

Many refugees are reluctant to make use of American mental health systems both because of a perceived stigma and because the American definition of, and response to, mental illness is so alien to Southeast Asian and other refugee cultures. Yet, once refugees begin to receive help from paraprofessional and professional mental health staff many clearly benefit from and continue to make use of the western system. Several approaches were used by the programs in this handbook to address this dilemma:

- **Location in a physical health care setting.** Some of the more successful refugee efforts are located in a primary health care center or hospital. Usually they are known and viewed as an extension of a physical health care agency

rather than a separate "mental health clinic." This arrangement allows for a natural and non-threatening transition from a primary care physician (who recognizes a somatic condition) to a psychiatrist or mental health professional in the same building. In addition, the patient and the staff can more easily regard the mental health service as part of a spectrum of care for the troubled refugee, de-emphasizing the distinction characterizing the patient as needing relief from physical pain or discomfort. This view is particularly helpful in outreach efforts. Frequently the bicultural worker will emphasize help available at the center for physical ailments, beginning with a physical and diagnostic tests from a primary care physician. Moreover, once mental health treatment begins, the refugee can appear to be going to the "doctor" at the center rather than to a mental health practitioner.

- **Home visits and other outreach efforts. Several of the programs** rely on home visits by paraprofessionals to reach reluctant patients and offer adjustment counseling and or other kinds of non-clinical assistance. Home visits allow for the development of trust between the client and the bicultural worker in a non-threatening setting. The worker can then help the client adjust to the idea of using the center for therapy, if needed, allaying fears and concerns beforehand. Home visits also allow the worker to observe the client's problem in the full context of the home environment.

- **Public health home visits** proved to be a particularly effective method of identifying mental health problems in Fresno and Minneapolis. Under this model, a multi-disciplinary team of public health workers (e.g., environmental health, public health, and mental health) makes home visits to assist refugees with a range of problems such as rat control, housing conditions, and immunizations. As mental health problems become apparent they can be addressed by the appropriate team member who may then become the bridge to clinical mental health services.

2. Develop an Appealing and Non-threatening Clinical Environment

Most of the programs in this handbook made explicit efforts to develop an inviting and comfortable atmosphere for their clients. This often begins with the program name, which avoids reference to mental health and emphasizes the support function of the program, i.e., "New Hope," 'Southeast Asian Support Center," and "Asian/Pacific Center for Human Development." The Torture Center in Minneapolis is located in a house which is decorated with artwork from its client's homelands.

Also important is the receptionist function. Some of the programs learned in their early stages that potential clients were often not well embraced, and even offended, by their

first contact with the program, either in person or by phone, because of language limitations or the unsympathetic demeanor of untrained receptionists. These programs quickly recognized the importance of language and cultural sensitivities at the point of a refugee's first contact with the program, and changed their staffing accordingly.

3. Use a Multidimensional Treatment Approach

Refugee mental health problems are rarely uni-dimensional. Successful programs provide either direct services or carefully coordinated referrals for such closely related problems as physical health care needs, child abuse/spouse abuse, housing problems, financial problems, transportation needs, drug and alcohol issues, and barriers to cultural adjustment. A common treatment method, in fact, begins by addressing these related issues and then gradually introduces mental health therapies once some of the more severe obstacles are removed and the client becomes more comfortable with the program or therapist. Frequently, the support service being provided becomes a natural context for mental health counseling, such as when a refugee client begins to discuss his/her problems while being driven by a social worker to a job interview or to a doctor's appointment.

This multidimensional approach can be important not only for persons with severe mental health conditions, but also for refugees experiencing adjustment difficulties and the other stresses of resettlement in a new country. Several program administrators and practitioners noted the preventive nature of many supportive services and focused considerable attention on dealing with a full range of non-psychiatric resettlement problems for clients with less severe conditions,

One of the reasons for the effectiveness of this multidimensional approach is probably its compatibility with the "world view" of many non-Western cultures. In many Asian societies, disease is considered a product of a loss of natural equilibrium of body, mind, and nature, and thus only the restoration of the harmony that should properly exist among them can constitute a return to health. Accordingly, the resolution of what Westerners call a mental health problem will result not from a unitary response or treatment (e.g., clinical therapy

sessions) but from a more comprehensive response to the needs of the body, mind, and a person's environment.

A way of strengthening this multidimensional treatment approach is to incorporate ethnic healing methods into mainstream therapies. American-born professionals sometimes find the use of traditional ethnic methods difficult to accept, but the benefits are evident in several of the cases. Importantly, we found that these efforts need not be extensive or elaborate to be meaningful for the refugee clients. The comfort level and therapeutic responsiveness of clients can be enhanced considerably by a visit to the temple by the therapist, including a monk in a therapy session, or offering acupuncture as a service. (The Technical Assistance Center in Minneapolis has prepared extensive materials on traditional healing methods and successful efforts at merging them with traditional mental health services.)

4. **Encourage a Team Approach Between Bicultural and Professional Staff**

In most of the programs examined for this handbook, bicultural workers functioned as partners in therapy sessions with American-born professional staff, assisting directly with discussions and helping the professional explore patient problems. This approach appears far superior to the more circumscribed role played by bilingual workers who are viewed and treated as little more than interpreters. Repeatedly we were told of the need for cultural interpretation of events and reactions, the subtle understanding of phrases and responses, and the ability to use the cultural nuances of communication that can only occur when the bicultural worker is a full participant in the therapy process. Moreover, clients understandably feel more comfortable communicating directly with a bicultural worker, particularly if the worker has himself or herself undergone the traumas of the refugee experience. In-that sense, the bicultural worker must be truly bicultural -- comfortable with both the traditional and US. cultures.

The effectiveness of the team approach can be reinforced through formal and informal training. Several of the programs emphasize a "two-way" training process whereby

the professional staff instruct the bicultural workers on therapeutic techniques and the bicultural workers help the professionals understand the refugee culture and experience.

5. Ensure Coordination and Linkages With Other Service Systems

The need for coordination is especially apparent in the relationship between physical and mental health services. As discussed earlier, successful programs had well-established relationships with physicians likely to make referrals for somatic conditions. Likewise, mental health workers need access to consultation and testing for conditions that may entail or be related to physical health problems.

Other agencies with which successful programs established linkages include:

- Schools, where family and intergenerational conflicts often become most apparent;
- Police, the courts, and other law enforcement officials;
- Refugee service agencies, including voluntary resettlement agencies, MAAs, and employment service providers; and
- Cash and medical assistance offices, another contact point for refugees where problems can become apparent.

C. FINANCING THE PROGRAM

Earlier in this chapter, guidelines were offered for building support in the community for refugee-specific mental health services. This support is the main building block in obtaining funding for new services. Beyond this, however, the case studies in this handbook suggest four specific guidelines **for building a sustainable funding base as follows.**

1. . Focus on Establishing Service Capacity, Regardless of Initial Size

Whether deliberately or not, almost all of the programs in this handbook used a strategy of "starting small." In each case, funding and commitment was obtained initially for a

single staff person or circumscribed program, with more extensive fund raising efforts undertaken as acceptance and demand for the specialized services grew. In 'effect, refugee advocates concentrated on "getting a foot in the door" for refugee-specific funding and services.

For several of the programs, starting small was probably their only choice when faced with constrained public financing and competing needs from other populations. Regardless of how services were initiated, however, the "foot-in-the-door" strategy allowed **for** a gradual development of sustainable support from several key constituencies:

- **Staff in mainstream agencies** who were often ambivalent about the role and potential effectiveness of bicultural staff, but began to change their views as they observed the program in action. Administrative and clinical staff in one mental health center, for example, described an evolution in thinking as they realized not only that their new bicultural worker was sorely needed, but that the service model itself needed expansion to include outreach, home visits, and a team-oriented treatment approach with clinical staff. Internal support of this type can be an important building block in sustainable funding, especially in organizations where staff can influence funding priorities.

- The ethnic community and potential clients who gradually came to trust the program in a way that may not have been possible with larger, more formal efforts. Once refugee concerns about stigma were allayed, most of the programs saw a marked increase in demand. This in turn allowed program directors to make a case for expanded resources.

- Funding agencies which were often faced with tangible proof of need as the small efforts produced more demand for services. The initial success of the Zumbro Valley "New Hope" program, for example, allowed senior staff at the Community Mental Health Center to make a convincing case for additional block grant funding from the state and matching dollars from the county.

Support from these groups has often proved durable despite financial constraints, reinforcing the need for establishing at least some services no matter how limited. In both Lynn and Rochester, mainstream agency support for bicultural services has remained strong despite fiscal constraints at the state (in Massachusetts) and local (in Minnesota) levels. Yet, neither program would likely have received initial financial support in the current fiscal environment.

2. Cultivate Diversified Funding Sources, Relying on Neither One Type of Funding Nor One Type of Service

Some of the more successful projects recognized the diverse needs and characteristics of their client populations, and then designed programs and funding strategies accordingly. Rather than viewing their clientele as homogeneous refugees, they recognized the special needs of the elderly, widows, children, substance abuse victims, and others. This in turn broadened the array of potential funding sources for their programs to include not just mental health funding, but also support for such specialized services as:

- alcohol and drug abuse counseling,
- spouse and child abuse issues,
- recreational programs for youth, and
- nutrition programs for the elderly.

This broadened view of need can be helpful with private foundations as well as public agencies. One program, emphasizing its concern with the abuses that caused the problems experienced by its clients, was able to obtain funding through a foundation human rights program. Several programs successfully tapped into United Way funds and foundation support by demonstrating special needs of refugees and proposing innovative program approaches likely to appeal to private donors and foundation boards.

3. Maximize Medicaid Payments

Several of the programs featured in this handbook have found ways to tap into Medicaid finding, providing a stable financial base for ongoing services. Of particular importance, although not always easily achievable, is the certification of paraprofessional bicuitural staff so that their services are eligible for Medicaid payment.

Medicaid is a nationwide health care coverage program for selected low-income populations. The Federal government and the states fund the program jointly, with the

Federal government providing matching funds at a rate based on state per capita income. While the Federal government establishes and enforces regulations and guidelines for the program, states have considerable latitude in establishing who will be covered, with what services, and by what types of providers, Thus your ability to obtain Medicaid financing for refugee mental health services will depend substantially on the rules governing the program in your state.

This section describes six issues that should be examined to determine the potential for Medicaid financing in your particular state:

- Eligibility and enrollment of refugees
- Coverage of services
- Certification of practitioners
- Provider billing procedures
- Reimbursement and payment policies

The discussion may also help you advocate for more extensive Medicaid coverage in states where opportunities for Medicaid reimbursement are limited.

a. Eligibility **and enrollment of refugees**

The first step in exploring the potential for Medicaid reimbursement is to determine who can qualify for Medicaid in your state. Many refugees and refugee advocates are under the mistaken impression that Medicaid (and the related Refugee Medical Assistance program) is limited to persons who are receiving cash welfare assistance. In fact, some working persons ineligible for cash assistance may be able to obtain ongoing Medicaid coverage.[1] Successful mental health programs are generally well informed on the range of populations that can qualify for Medicaid, and they often have trained staff persons who help clients

[1] Working persons may be eligible for cash assistance as well, depending on state income eligibility thresholds and the income of the family.

determine their potential eligibility for public programs and assist these individuals in registering for Medicaid.[2]

Eligibility for Medicaid is linked primarily to eligibility for two cash welfare programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). These programs generally have low income eligibility levels (as well as asset limits) and are limited to single-parent families and two-parent families with an unemployed breadwinner (AFDC), and the elderly, blind, and disabled (SSI). Because of this linkage to welfare programs, Medicaid often appears to be restricted to the non-working poor. The income eligibility level for AFDC, for example, is well below the Federal poverty level in most states, ranging from 18 percent of poverty in Alabama to 84 percent of poverty in California.

Increasingly, however, Medicaid is available to a broader population than traditional welfare recipients. First, a form of Medicaid called Refugee Medical Assistance is available (along with Refugee Cash Assistance) for an initial period a refugee is in the U.S.[3] Refugees can also qualify for the regular Medicaid program, but Refugee Medical Assistance allows coverage for single adults, childless couples, and other population groups barred from AFDC and SSI.

Second, there are several eligibility categories available to both refugees and non-refugees who cannot qualify for cash assistance. Many children, for example can qualify for Medicaid, regardless of their family composition, at income eligibility levels much higher than for AFDC. The same is true for pregnant women. Moreover, Medicaid often extends for several months after a family loses eligibility for AFDC due to an increase in earnings. Also, a component of Medicaid known as the "Medically Needy" program allows many persons to

---

2 While ORR and the State Department are encouraging refugees to obtain employment and leave (or avoid) cash assistance as soon as possible after arrival, they recognize that many employers do not offer health insurance and that Medicaid medical coverage may be needed as the family makes the transition to self-sufficiency.

3 States use varying names for this program, and may simply refer to it as a part of a broader state- or locally- financed medical assistance program (often called "General Assistance" or "General Relief") for non-AFDC populations.

qualify even if their income is somewhat above the state's income eligibility thresholds for cash assistance. Thus many refugees in need of mental health supports may qualify for Medicaid even if they cannot obtain cash assistance. Because rules governing eligibility can vary from one state to the next, specific information governing these and other groups should be obtained from a state or local public assistance office.

b. Coverage of services

Your ability to obtain Medicaid reimbursement will also depend on the particular mental health services covered by your state. As shown in Exhibit 111.2, the Federal government requires states to provide a core set of "mandatory" services, some of which will include mental health care. Inpatient hospital care is mandatory for all ages and for all services, including psychiatric care, although many general hospitals do not offer psychiatric care. Physician services are also mandatory, meaning reimbursement is generally available for care from psychiatrists,

Beyond these mandatory services, however, Medicaid can be very restrictive in coverage of mental health needs. This is in part because some services are excluded by Federal law. Persons between 22 and 65, for example, are not eligible for care from psychiatric hospitals. Nor is coverage allowed for the costs of residential facilities such as halfway houses and adult foster homes for people with mental illnesses.[4]

---

[4] Much of the information in this section comes from: Medicaid Sourcebook: Backaround Data and Analvsis (Report prepared by the Congressional Research Service for use of the Subcommittee on health and the Environment, November 1988) and Chris Koyanagi, Operation Help: A Mental Health Advocate's Guide to Medicaid (National Mental Health Association, 1988).

EXHIBIT III.2

MANDATORY AND OPTIONAL SERVICES UNDER MEDICAID

MANDATORY SERVICES

- Inpatient hospital services (other than psychiatric hospitals).
- Outpatient hospital services.
- Physician services.
- Laboratory and x-ray services.
- Nursing facility care (other than care in an Institution for Mental Diseases).
- Early and periodic screening, diagnosis and treatment services for children,
- Family planning services.
- Rural health clinic services.
- Services of nurse midwives.

OPTIONAL SERVICES

- Medical or other remedial care recognized under state law and furnished by professionals who are licensed practitioners under state law, including psychologists, psychiatric social workers and other mental health professionals,
- Home health care (which can include mental health services) if provided by a home health agency that meets Medicare requirements, or if furnished under the supervision of a registered nurse and prescribed by physicians.
- Prescribed drugs.
- Other diagnostic, screening, preventative, and rehabilitation services.
- Psychiatric inpatient hospital services and nursing facility services for individuals age 65 and over in an institution for mental diseases.
- Intermediate care facility services for persons with mental retardation.
- Inpatient psychiatric hospital services for individuals under the age of 22.
- Targeted case management.

More important, however, is the fact that optional Medicaid services (see Exhibit 111.2) are not always covered by states. Moreover, both mandatory and optional services are subject to restrictive limitations. States can place limits on the number of visits, number of days, and the length of time and exact type of service for which reimbursement is available. States can also use prior authorization or other mechanisms for withholding reimbursement in cases where treatment is deemed to be unnecessary.

Some states may offer optional services (or components of them) through their public mental health system but at full state (or local) cost rather than with the Federal "match" available through Medicaid. Many of these states are realizing the advantage of obtaining Federal dollars for these existing efforts and have begun to adjust their Medicaid plans accordingly. If you are located in such a state, you may find that new funding opportunities become available as the state taps into new Federal Medicaid dollars.[5]

Of the various optional services that may be available in your state for refugees in outpatient therapy settings, five are worth particular attention?

- Clinic services. Almost all states reimburse for clinic services, a category that usually includes freestanding clinics and community mental health centers. To be a qualified clinic in most states requires approval from the state Medicaid agency or the state mental health authority. Qualifying rules for mental health services vary widely, but often require that the clinic offer a comprehensive range of community mental health services. Certification is sometimes limited to centers within the state mental health system.

  Federal law requires that the clinical program be directed by a physician, and most states require supervision of care by a psychiatrist. States vary in how they define "supervision," but often stipulate that the psychiatrist develop or approve the treatment plan and then review the case periodically (such as every four months). Within this supervision requirement, states generally allow

---

5 See, for example, Lewin/ICF and Fox Health Policy Consultants, Studv and Plan for Maximizing Federal Medicaid Funds for Hawaii (A Report to the Governor and the Legislature of the State of Hawaii submitted by the Legislative Auditor of the State of Hawaii, 1990).

6 Koyanagi, p. 50.

reimbursement for services by all professional clinic personnel, often specified to include psychologists, psychiatric nurses, and psychiatric social workers.

Activities that can be covered under the outpatient clinic option are listed in Exhibit 111.3. Again, however, states have considerable leeway in defining reimbursable activities, and some impose limits on visits or dollars per patient. Specifically excluded by Federal regulation are "off-site" services (except for care to the homeless), a particular drawback for refugees because of the effectiveness of home visits in many programs.

Several of the programs in this handbook rely on Medicaid funding through the clinic option, at least for the professional services provided to refugees. In most states, obtaining Medicaid reimbursement for clinic services is relatively straightforward, although some specialized refugee programs had to make a concerted effort to comply with state certification requirements. In Colorado, for example, certification is largely restricted to providers in the state mental health system, an obstacle overcome only because the Pan Asian Center was able to make a convincing case for its specialized role in that system. The certification problem can also be avoided by developing refugee capabilities within centers that are already certified or by establishing subcontract or "satellite" arrangements with certified providers.

- **Medical or remedial care provided by licensed practitioners.** States have the option of allowing reimbursement for certain non-physician practitioners outside the certified clinic setting described above. About 30 states cover care by psychologists, often requiring some form of physician supervision or referral. A few states cover psychiatric social workers, As with other practitioners, limits are often imposed on the number of visits, type of services, or level of care provided by these professionals.

- **Case management.** Case management is defined by Medicaid as services which assist eligible individuals to gain access to needed medical, social, educational, and other services. While many states have traditionally offered case management as a part of other services, a 1986 change in Federal law allowed for "targeted case management" giving states the option of restricting the function to population groups or geographical areas with special needs.

  States must specify the population and services to be provided, but one of the groups explicitly allowed under the law are the "chronically mentally ill." Case management services can be provided either by or under the direction of a mental health professional. Case managers cannot, however, bill for direct therapeutic services. Typically, states using this option have limited it to organized care settings such as community mental health centers.

  The broad definition of case management under Federal law allows states considerable flexibility in defining reimbursable activities. Exhibit III.4 lists the range of activities that have been specified by states. Services explicitly

Exhibit III.3

SERVICES ELIGIBLE FOR REIMBURSEMENT THROUGH THE MEDICAID CLINIC OPTION

Emergency services and crisis services.

Evaluation, diagnostic services, assessment, psychological testing.

Establishment of a plan of care, treatment planning.

Case management.

Individual therapy, group therapy, family consultations, family therapy, biofeedback, hypnotherapy, conjoint therapy, electroshock therapy.

Telephone services, home visits.

Medication prescription and monitoring.

Screening, referral, follow-up services.

Aftercare, residential facility placement.

Day treatment, day hospitalization, partial hospitalization (see below).

Vocational rehabilitation, sheltered workshop, supported employment.

Social rehabilitation, activity therapy, training in basic living and social skills, recreation therapy, self-care.

Occupational therapy, speech therapy, physical therapy, restorative or preventive physical exercise.

- Dietary services.
- Consultation.
- Transportation.

disallowed by Federal regulation include direct nursing care, psychological counseling, education services, and outreach.

Among the programs in this handbook, the Lowell Community Health Center was able to hire its bicultural refugee worker under the case management function. Massachusetts recently introduced case managers into its mental health system, and the resulting funds allowed the Lowell Center to hire this worker without displacing existing staff. A drawback of this arrangement, however, is that the worker in that slot cannot receive Medicaid funds for direct mental health therapy. Currently the Lowell worker is not involved in joint therapy sessions with Center professionals (except for translation) but, as discussed earlier, a team therapy approach can be one of the more effective ways of serving the refugee population.

- **Transportation.** Transportation expenses required to ensure that a patient receives an examination or treatment are covered by all states except the District of Columbia. Transportation includes travel expenses (taxi fare, bus fare, etc.) and the cost of meals and lodging if necessary. Most states require prior authorization for transportation expenses or have placed other restrictions on the use of this service.

- **Prescription drugs,** Almost all states' Medicaid programs cover prescription drugs, although they often impose limits on the type or allowable number of prescriptions. Cost sharing by patients may be required.

c. Certification of practitioners

Even if an outpatient clinic is Medicaid-certified, reimbursement is usually not available for services provided by non-professionals. Clinic psychologists, psychiatric nurses, and psychiatric social workers are usually reimbursable, but allowable providers beyond these definitions vary widely according to state licensure and certification requirements. This is particularly important in the case of bicultural workers, many of whom do not have either college or professional degrees. Efforts to encourage and/or directly support work toward a degree by bicultural workers may be worthwhile because of the stable funding foundation offered through Medicaid reimbursement. As discussed in the final section of this chapter, this is a particularly promising route in states where a BA degree is sufficient for certification,

Exhibit III.4

REIMBURSEMENT **FOR CASE MANAGEMENT UNDER MEDICAID**

Targeted case management has recently become a covered option under many state Medicaid programs. This option allows for the reimbursement of services provided by a bilingual paraprofessional who, while not providing actual mental health services, serves as a critical link between the refugee community and the service delivery system.

Under Medicaid, case management services are defined as those which assist eligible individuals to gain access to needed medical, social, educational, and other services, such as housing, vocational services, and financial assistance. Case management may be provided for an indefinite period of time, based. on the client's level of impairment, dysfunction, or need. These services may be furnished by a mental health professional or under the direction of a mental health professional; Such services, however, may not include those which are an "integral part" of other services, nor may case managers be reimbursed for actual therapeutic services.

States allowing the case management option include such services as:

- Coordination of assessment and treatment services.
- Facilitating access to services.
- Assessments.
- Treatment planning.
- Crisis assistance planning.
- Linkage between the Medicaid eligible client's needs and services.
- Coordinating the training of the client to use basic community resources (such as transportation).
- Monitoring the overall delivery of services and the client's progress.
- Social support.
- Promoting treatment or community adjustment and building a support network by establishing contacts with client's significant others.
- Advocacy to ensure that services are appropriate to the client's needs and to assist clients in obtaining benefits to which they are entitled.

Source: Chris Koyanagi, Operation Help: A Mental Health Advocates Guide to Medicaid. National Mental Health Association, 1988.

d. Provider billing procedures

Assuming your program is certified for Medicaid and that most practitioners can be reimbursed, the next step is to ensure that the provider organization is maximizing Medicaid dollars by identifying eligible clients and billing the state for services. Some mental health centers devote little staff time to this process. As a result, the program may be providing free or discounted care to refugee clients who are eligible for Medicaid but have not signed up for the program or have not supplied their Medicaid card to the billing office.

e. Reimbursement and payment policies

It should be noted that efforts to secure Medicaid reimbursement for refugee mental health services may not be worthwhile financially, especially when compared to other potential funding sources such as private foundations and state block grant funds. In weighing the potential for Medicaid funding, you should examine:

- **Reimbursement rates** which may be very low for some practitioners and for particular services.
- **Administrative requirements,** including paperwork and billing procedures, which may simply be too burdensome for many small or new providers.
- **Payment policies** which may entail delays that can create serious cash flow problems for some providers.
- **Prior authorization and utilization review requirements** which may result in the disallowance of many services and fewer payments overall than would at first appear possible through Medicaid certification.

4. **Maximize Other Third-Party Billings**

Some of the programs in this handbook are aggressive not only in obtaining Medicaid reimbursement but also in making claims to private insurance carriers whenever possible. Private insurance coverage for mental health care varies by state and community. Some states have “minimum benefit” laws which require coverage for certain services including mental health therapy. In other states, mental health coverage may be minimal.

Also to be considered is the extent to which your refugee clientele is insured or likely to become insured. Many employers do not offer insurance and those that do may require substantial cost sharing by employees. For refugees who cannot or have not taken insurance through their jobs, options for Medicaid eligibility should be explored, as described earlier.

5. Capitalize **on Special Funding Initiatives**

Several of the programs in this handbook were in "the right place and the right time" and were knowledgeable about special funding initiatives that helped them considerably in their formative stages:

- The Fresno program administrator kept in close touch with county officials and was able to tap into one-time "roll over" funds to get the effort established.
- Providers in Massachusetts were well informed and aggressive about obtaining "Governor's Message" funding which allowed for several new mental health initiatives during a time when refugee advocates were looking for more culturally sensitive services.
- The Rochester, Minnesota, effort was effective in exploiting state "innovative program" funds to shore up its refugee program.

D. STAFF RECRUITMENT AND DEVELOPMENT

An essential element of each of the successful programs presented in this handbook was the involvement of dedicated, well-trained staff. Effective programs often had staff with two sets of skills: mental health professionals who developed a knowledge of the refugee population and their culture; and bicultural staff who developed expertise regarding mental health service delivery. In some programs, these staff were one and the same person, with a bilingual professional filling both roles. In others, western trained professionals worked with bicultural paraprofessionals and interpreters.

Recruitment of appropriate staff has been a challenge for many refugee mental health programs. Poor staffing decisions -- whether in finding individuals with professional

credentials or community standing -- hold the potential for creating major problems for the programs, Some programs have found it difficult to find clients because they recruited individuals who were not trusted by the refugee clients. Other programs have found it difficult to obtain funding, particularly from Medicaid, for their refugee staff because of lack of certification.

As pat-t of the RAP-MH initiative a directory of bilingual professionals was developed. Recognizing the importance of increasing the pool of available people, one of the goals of the RAP-MH initiative was to develop opportunities for refugees to obtain advanced educational training in the mental health field. These efforts met with limited success, however. A number of states produced directories of mental health training programs available to refugees and made contacts with universities to encourage their participation. While a number of universities increased their understanding of the needs of refugees and indicated a willingness to recruit refugee students, relatively few people were actually trained. In some cases, the refugees themselves were reluctant to enroll because of financial or other constraints. In other cases, the increased interest. on the part of the universities did not translate into concrete actions to recruit the students.

A number of the programs described in this handbook have developed their own strategies for recruiting staff and for encouraging existing staff to increase their professional skills. From these case studies, five lessons emerged regarding how best to facilitate staff development for refugee workers.

1. Ensure That Bicultural Staff Hired into Mainstream Positions are Well-Regarded Within the Local Refugee Community

Many of the model programs described in this handbook made great efforts to consult with refugee community leaders prior to hiring staff in order to ensure that they recruited individuals who would be trusted by their clients. The mental health service relationship requires clients to communicate the most personal issues in their lives. If clients perceive the therapist as being inappropriate (by age, gender, clan memberships, etc.) or untrustworthy (because of political affiliation, for example), they are unlikely to benefit from the

services. Older clients may, for example, refuse to discuss family issues with a young, U.S.-trained therapist.

Consultation with community leaders is particularly important in recruiting staff in a refugee context because of differences in cultural values and because of the refugee experience itself. It is important for an agency contemplating refugee services to find out what type of staff member would be most appropriate in a given situation given the cultural values of the specific refugee community. Also, in dealing with torture victims or others who have suffered persecution, it is important to recruit staff who are not identified in any way with those who caused the persecution.

Recruitment of appropriate bilingual staff may mean some accommodation on the part of the mental health agency. Some of the staff who will be most trusted may be least "westernized." They may wear different clothing and follow different cultural practices. The trade-offs will likely be worth it, however, because of the confidence that they instill in clients.

2. **Recognize and Make Accommodations for the "Dual Role" of Staff as Refugee Leaders and Bicultural Workers**

Many of the model programs in this handbook found an additional benefit from hiring staff who were well connected with the refugee community. In their roles as community leaders, the staff were able to accomplish a great deal of outreach, identification of needs, prevention of problems, and education, These programs often adjusted the schedules of their staff to help enable them to continue to serve as community leaders -- for example, by allowing a staff person to leave work early in order to organize a fundraising event for a Buddhist temple.

3. Encourage a Sense of Professional Development and Autonomy for Bicultural Staff

Failure to view bicultural staff as valued staff that bring many resources to the agency can result in high turnover, low morale, and less effective services. By contrast, the

most successful programs provided opportunities for their refugee staff to demonstrate their professional competence, knowledge of the population, and understanding of the needs of their clients, For example, bicultural staff were asked to prepare presentations on the refugee clients and the experiences they had undergone. Such activities in turn helped refugee staff build greater credibility with the U.S. born staff and to increase their effectiveness as service providers.

Many of the most successful programs tended to emphasize a team approach to services, with bicultural workers viewed as an equal partner in the therapy process. This approach includes therapy sessions jointly staffed by a bilingual paraprofessional and western-trained professional; joint staffings involving not only the mental health staff but other refugee service providers to discuss the needs of the client; independent intake and counseling activities conducted by bilingual staff; and home visits by the bilingual staff.

Successful programs also emphasized opportunities for career advancement for bicultural staff. Related to efforts to encourage advanced training (see below), career advancement opportunities were clearly spelled out and attainable. In some cases, the advancement could come within the agency itself; in other cases, the agency offered to help its bilingual staff find more advanced positions in other, larger organizations. The Refugee Assistance Division of the Jewish Board of Family and Children's Services, for example, has as one of its goals placement of its own staff in other programs operated by JBFCS. It is intended to serve two purposes: to give staff an opportunity for advancement and to ensure that clients will be able to access these other programs.

4. **Sponsor In-Service Training for Staff**

Effective in-service training programs have proven to be essential components in model programs for both western professionals and bicultural staff. The training programs for the western staff have generally emphasized the special experiences and needs of the refugee clients. Their aim is to make the western staff more culturally sensitive and aware of cultural differences. A number of programs utilized their bicultural staff as trainers, thereby increasing their credibility among western staff. Some programs also provided training in use

of interpreters and translators to help their western staff become more proficient in interviewing and counseling patients.

In-service training for bicultural staff more often focused on recognition of symptoms and mental health service delivery techniques. The bilingual staff who were utilized as interpreters also received training in this specific area.

5. Encourage Advanced Training **for Existing Bicultural Staff**

According to many service providers, the ideal staff person for providing mental health services to refugees is a bicultural professional who is certified as a counselor. Clinical social workers, psychologists and psychiatrists are all valued if they are refugees themselves. They hold several advantages:

- They can provide direct services without need of an interpreter;
- They understand the experiences and culture of the client in a way that only someone who has had the same experiences can; and
- Services provided by certified professionals can qualify for Medicaid reimbursement, thereby permitting the agency to obtain an important source of funding.

Unfortunately, there are too few refugee professionals to meet the demand of these programs. As a result, there has been a concerted effort to identify potential applicants for advanced training and to encourage them to participate in training programs. Several of the case studies provide examples of successful models for doing this.

First, it is important to provide the refugee workers with the financial capacity to enter a training program. Several agencies have provided financial support for tuition and paid leave time to workers who are willing to work toward a degree in a field related to mental health services. The Jewish Board of Children and Family Services, for example, has arranged **for scholarships for six of its paraprofessionals at a school of social** work and will pay them while they are in school. In exchange, the workers will remain at the program for

their school placement (thereby giving back some of the paid time off) and must agree to work at the agency after graduation.

Second, agencies have developed very close working relationships with university programs to encourage their interest in refugee issues. JBFCS utilized its connections to the Yeshiva University social work school to obtain the scholarships referenced above. Most of MICAS's staff have gone through a training program at Boston University. Faculty from the University of Minnesota serve as consultants and staff at the Torture Victims Center. These contacts have a number of benefits, in addition to paving the way for the enrollment of refugee students. They bring added expertise to the refugee mental health services. They also increase the likelihood that these universities will add course materials on cross-cultural issues so that all of their students will be exposed to the need for cultural sensitivity in their work.

A summary of each of the above guidelines is offered in the form of an "index" in Appendix A. For each guideline, we have listed types of activities and the case study programs that can serve as illustrative examples. You may find it useful to use the index to review actions for your own program or activities.

APPENDIX A:

INDEX TO CASE STUDY EXAMPLES
LESSONS FOR PROMOTING MENTAL HEALTH SERVICES FOR REFUGEES

INDEX TO CASE STUDY EXAMPLES:
LESSONS FOR PROMOTING MENTAL HEALTH SERVICES FOR REFUGEES

INDEX TO CASE STUDY EXAMPLES:
LESSONS FOR PROMOTING MENTAL HEALTH SERVICES FOR REFUGEES
(Continued)

LESSONS FROM LOCAL EFFORTS (PART III)	**ILLUSTRATIVE** CASE STUDY EXAMPLES (PART II)		
	PROGRAM	DESCRIPTION	PAGE(S)
3. *Build support within the Refugee Community.*	Asian/Pacific Center for Human Development (Denver, CO)	Broad refugee community support.	48-50
	Community University Health Care Center (Minneapolis, MN)	Input and support from refugee community.	32-34
	Metropolitan Indochinese Children and Adolescent Services (Boston, MA)	Close ties with refugee community.	67-69
	Mobile Team (California)	Support from MAA.	85
	Solomon Mental Health Center (Lowell, MA)	Consultation with refugee community in selecting staff.	18, 20
	Southeast Asian Women's Alliance (Seattle, WA)	Close ties with refugee community.	71-75
	Union of Pan Asian Communities (San Diego, CA)	Broad refugee community support.	53-55
4. *Build Internal Support.*	Lynn Community Health Center (Lynn, MA)	Development of professional staff support for bicultural worker.	24-27
	Solomon Mental Health Center (Lowell, MA)	Development of professional staff support for bicultural worker.	20
5. *Make strategic use of information.*	Asian/Pacific Center for Human Development (Denver, CO)	Efforts to inform key lawmaker.	48-50
	Southeast Asian Mental Health Unit (Fresno, CA)	Efforts to inform key county representatives.	11-14
	Union of Pan Asian Communities (San Diego, CA)	Efforts to inform key county representatives.	53-55
	Zumbro Valley "New Hope" program (Rochester, MN)	Efforts to inform the provider (initially) and state officials.	4-6

INDEX TO CASE STUDY EXAMPLES:
LESSONS FOR PROMOTING MENTAL HEALTH SERVICES FOR REFUGEES
(Continued)

LESSONS FROM LOCAL EFFORTS (PART III)	ILLUSTRATIVE CASE STUDY EXAMPLES (PART II)		
	PROGRAM	**DESCRIPTION**	**PAGE(S)**
6. *Promote a better understanding of Refugee needs in the public mental health system.*	Lynn Community Health Center (Lynn, MA)	Gradual education of area mental health agency.	26-27
	Solomon Mental Health Center (Lowell, MA)	Education of state mental health staff by RAP-MH staff.	17
	Southeast Asian Mental Health Unit (Fresno, CA)	Education efforts within county mental health deoartment.	11-12
	Union of Pacific Asian Communities (San Diego, C A)	Efforts to communicate, coordinate with county mental health department.	51-54
B. DESIGNING THE PROGRAM			30-34
1. Rety on non-psychiatric settings when possible to avoid stigma.	Community University Health Care Center (Minneapolis, MN)	Physical health setting. Multi-disciplinary health team used to make home visits.	
	Lynn Community Health Center (Lynn, MA)	Physical health setting. Extensive use of home visits.	24-26, 28
	Refugee Assistance Division -- JBFCS (New York, NY)	Location in social service agencies	59-62
	Southeast Asian Mental Health Unit (Fresno, CA)	Multi-disciplinary public health team used to make home visits.	11-12
2. Develop an appealing and non-threatening clinical environment.	MOST CASE STUDIES		

INDEX TO CASE STUDY EXAMPLES:
LESSONS FOR PROMOTING MENTAL HEALTH SERVICES FOR REFUGEES
(Continued)

LESSONS **FROM LOCAL EFFORTS** (PART III)	**ILLUSTRATIVE** CASE STUDY EXAMPLES (PART II)		
	PROGRAM	DESCRIPTION	PAGE(S)
3. Use *a multi-dimensional treatment approach.*	Asian/Pacific Center for Human Development (Denver, CO)	Wide range of services; milti-dimensional service approach.	43-47
	Lynn Community Health Center (Lynn, MA)	Wide range of support and related services; particular emphasis on home visits.	24-27
	Refugee Assistance Division -- JBFCS (New York, NY)	Services provided in context of overall resettlement needs; continuity of assistance.	61-63
	Southeast Asian Mental Health Unit (Fresno, CA)	Emphasis on broad array of needs; follow-up care, home visits, support groups, interpretation.	10, 14
	Southeast Asian Support Center (Providence, RI)	Emphasis on multiple needs, especially physical, mental, and adjustment problems.	36-37, 40
	Southeast Asian Women's Alliance (Seattle, WA)	Emphasis on support services for women.	70-74
	Torture Victim Center (Minneapolis, MN)	Wide range of services.	76-80
	Union of Pan Asian Communities (San Diego, CA)	Wide range of services,	51-53
	Zumbro Valley "New Hope" Program (Rochester, MN)	Spouse abuse counseling; other support services; integration of traditional methods.	5-8
4. *Encourage* a *team approach between bicultural and professional staff.*	Community University Health Care Center (Minneapolis, MN)	Coordination with professional staff.	31, 34
	Lynn Community Health Center (Lynn, MA)	Team counseling and group-oriented therapy.	24-28
	Metropolitan Indochinese Children and Adolescent Services (Boston, MA)	Cross-cultural team approach.	65-69
5. *Ensure coordination and linkages with other service systems.*	Southeast Asian Mental Health Unit (Fresno, CA)	Linkages with welfare agencies and schools to help build political support.	14
	Torture Victim Center (Minneapolis, MN)	Linkages with university resources.	79-80
	MOST OTHER CASE STUDIES		

INDEX TO CASE STUDY EXAMPLES:
LESSONS FOR PROMOTING MENTAL HEALTH SERVICES FOR REFUGEES
(Continued)

LESSONS FROM LOCAL EFFORTS (PART III)	ILLUSTRATIVE CASE STUDY EXAMPLES (PART II)		
	PROGRAM	**DESCRIPTION**	**PAGE(S)**
C. FINANCING THE PROGRAM			
1. Focus on establishing service capacity regardless of initial size.	MOST CASE STUDIES.	(Process of starting small and then expanding was common in most of the case studies)	
2. Cultivate ***diversified funding sources, relying on more than one type of funding and one type of service.***	Asian/Pacific Center for Human Development (Denver, CO)	Wide range of services and funding sources.	43-47
	Community University Health Care Center (Minneapolis, MN)	Multiple grants from county and private-funds.	32-34
	Union of Pan Asian Communities (San Diego, CA)	Strategy to ensure multiple funding sources.	51, 55
	Zumbro Valley "New Hope" Program (Rochester, MN)	Public and private funds; federal and local; chemical dependency.	5-8
3. ***Maximize Medicaid payments.***	Asian Pacific Center for Human Development (Denver, CO)	Certification for Medicaid reimbursement.	49
	Southeast Asian Mental Health Unit (Fresno, CA)	Use of optional Medicaid case management function.	9-10
	Lynn Community Health Center (Lynn, MA)	Incentives for bicultural workers to obtain certification. Systematic approach to Medicaid billing.	26, 28
	Solomon Mental Health Center (Lowell, MA)	Use of optional Medicaid case management function.	18-20
	Union of Pan Asian Communities (San Diego, CA)	Efforts to become certified clinic.	55
4. ***Maximize other third-party billings.***	Asian/Pacific Center for Human Development (Denver, CO)	Efforts to collect other third-party payments.	49
	Lynn Community Health Center (Lynn, MA)	Efforts to collect other thirt-party payments.	26-29

INDEX TO CASE STUDY EXAMPLES:
LESSONS FOR PROMOTING MENTAL HEALTH SERVICES FOR REFUGEES
(Continued)

LESSONS FROM LOCAL EFFORTS (PART III)	**ILLUSTRATIVE CASE** STUDY EXAMPLES (PART II)		
	PROGRAM	DESCRIPTION	PAGE(S)
5. *Capitalize on special funding initiatives.*	Solomon Mental Health Center (Lowell, MA)	Use of new funds from governor's mental health initiative.	18
	Southeast Asian Women's Alliance (Seattle, WA)		70-74
	Southeast Asian Mental Health Center (Fresno,CA)	Use of one-time county "roll over" funds.	11
	Zumbro Valley "New Hope" Program (Rochester, MN)	Use of state "innovative program" funds	6
	MOST OTHER CASE STUDIES		
D. STAFF RECRUITMENT AND DEVELOPMENT			**28-29**
1. *Ensure that bicultural staff hired into mainstream positions are well-regarded within the local refugee community.*	Lynn Community Health Center (Lynn, MA)	Importance of bicultural staff members' connections with community.	
	Solomon Mental Health Center (Lowell, MA)	Process for selecting bicultural worker who was highly regarded by the community.	18
	Zumbro Valley "New Hope" Program (Rochester, MA)	Bicultural staff seen as leaders, informal helpers within ethnic community.	3, 4, 9
	MOST OTHER **CASE STUDIES.**		
2. *Recognize and make accommodations for the "dual role" of staff as refugee leaders and bicultural workers.*	Zumbro Valley "New Hope" Program (Rochester, MN)	Involvement of bicultural staff in community activities.	3,9

INDEX TO CASE STUDY EXAMPLES:
LESSONS FOR PROMOTING MENTAL HEALTH SERVICES FOR REFUGEES
(Continued)

LESSONS FROM LOCAL EFFORTS (PART III)	ILLUSTRATIVE CASE STUDY EXAMPLES (PART II)		
	PROGRAM	DESCRIPTION	PAGE(S)
3. *Encourage a sense of professional development and autonomy for bicultural staff.*	Community University Health Care Center (Minneapolis, MN)	Autonomy and responsibility afforded bicultural staff.	31-32
	Lynn Community Health Center (Lynn, MA)	Team Therapy approach; opportunities for career advancement.	27-28
	Metropolitan Indochinese Children and Adolescent Services (Boston, MA)	Staff development program, coordinated with promotions and pay increases.	67, 69
	Refugee Assistance Division -- JBFCS (New York, NY)	Opportunities for career advancement; internal training and placements.	61-63
	Union of Pan Asian Communities (San Diego, CA)	Commitment to and sense of professionalism for bicultural staff.	53-55
4. Sponsor in-service training for staff.	Community University Health Care Center (Minneapolis, MN)	Cross-training activities between bicultural staff and western professional staff.	31-33
	Refugee Assistance Division -- JBFCS (New York, NY)	Comprehensive in-service training programs.	61
	Southeast Asian Mental Health Unit (Fresno, CA)	Weekly consultations between bicultural and professional staff.	14
	Zumbro Valley "New Hope" Program (Rochester, MN)	Training of western professionals.	6-7
5. Encourage advanced training for existing bicultural staff.	Community University Health Care Center (Minneapolis, MN)	Encouragement of bicultural staff to obtain advanced training.	33
	Lynn Community Health Care Center (Lynn, MA)	Financial support to employees for continuing education in relevant fields.	26-27
	Metropolitan Indochinese Children and Adolescent Services (Boston. MA)	Support of staff training at local university.	67
	Refugee Assistance Division -- JBFCS (New York, NY)	Social work scholarships for bicultural employees; close relationships with university.	61-63
	Torture Victim Center (Minneapolis. MN)	Close relationship with universitv.	79-80

APPENDIX B

CASE STUDY PROGRAMS:

Addresses and Phone Numbers

CASE STUDY PROGRAMS:

Addresses and Phone Numbers

Zumbro Valley Mental Health Center
New Hope Refugee Services
2116 Campus Drive SE
P.O. Box 1116
Rochester, MN 55903
Phone: (507) 281-6240

Southeast Asian Mental Health Unit
Freso County Department of Health
2220 Tulare Street
Fresno, CA 93721
Phone: (209) 488-2800

Solomon Community Mental Health Center
391 Varnum Avenue
Lowell, MA 01854
Phone: (508) 454-8851

Lynn Community Health Center
P. 0. Box 526
86 Lafayette Park
Lynn, MA 01903
Phone: (617) 581-3900

Community University Health Care Center
2016 16th Avenue South
Minneapolis, MN 55404
Phone: (612) 627-4774

Southeast Asian Support Center
St. Joseph Hospital
21 Peace Street
Providence, RI 02907
Phone: (401) 456-4421

Asian Pacific Center for Human Development
1825 York Street
Denver, CO 80206
Phone: (303) 393-0304

Union of Pan Asian Communities
2359 Ulric Street
San Diego, CA 92111
Phone: (619) 232-6454

Jewish Board of Family and Children Services
Refugee Assistance Division
120 W. 57th Street
New York, NY 10019
Phone: (212) 582-9100

Metropolitan Indochinese Children and Adolescent Services
388A Broadway
Chelsa, MA 02150
Phone: (617) 884-7200

Southeast Asian Women's Alliance
3004 S. Alaska
Seattle, WA 98108
Phone: (206) 721-0243

*U.S. GOVERNMENT PRINTING OFFICE: 1991--525-997/40746